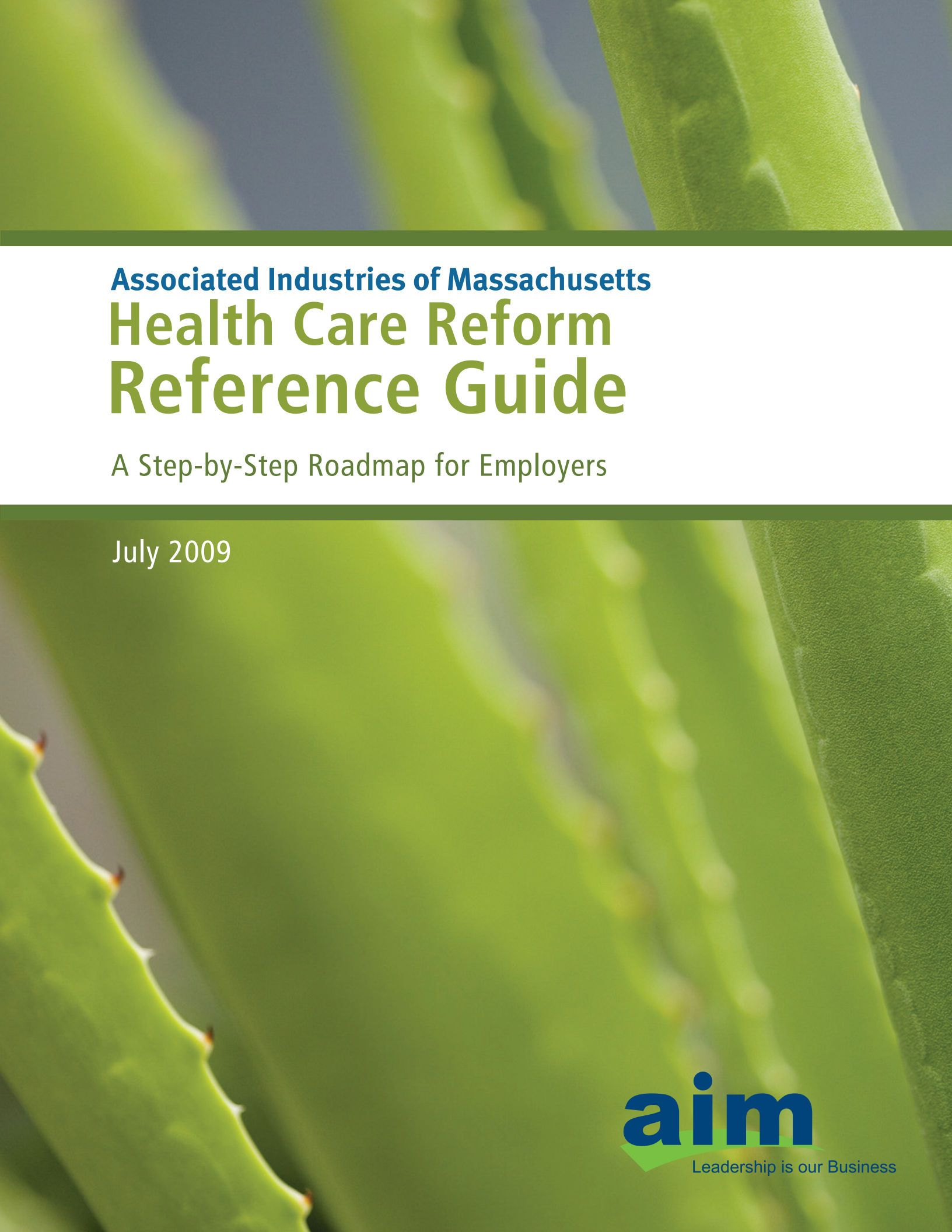

Associated Industries of Massachusetts

Health Care Reform Reference Guide

A Step-by-Step Roadmap for Employers

July 2009

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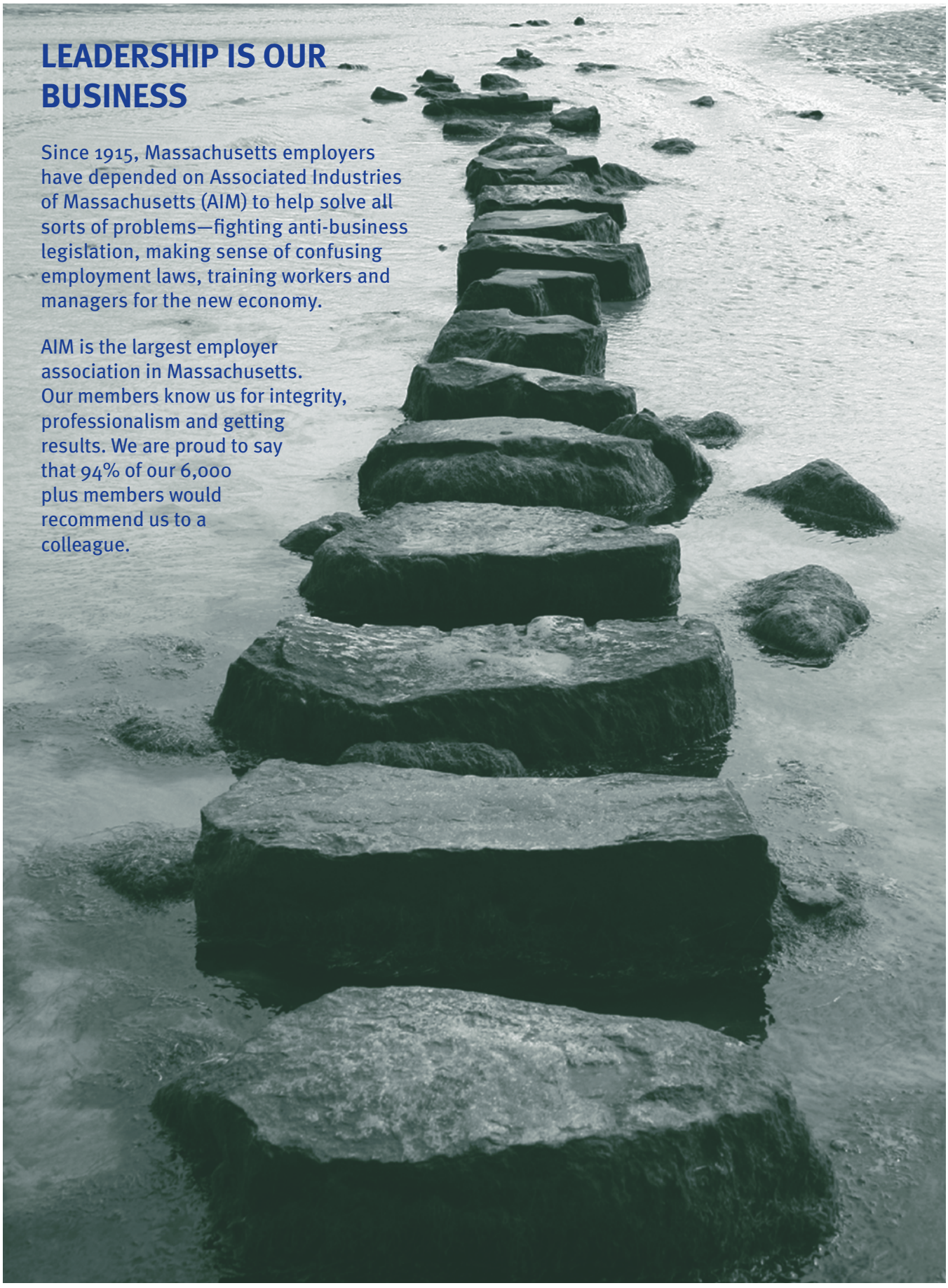
Leadership is our Business



LEADERSHIP IS OUR BUSINESS

Since 1915, Massachusetts employers have depended on Associated Industries of Massachusetts (AIM) to help solve all sorts of problems—fighting anti-business legislation, making sense of confusing employment laws, training workers and managers for the new economy.

AIM is the largest employer association in Massachusetts. Our members know us for integrity, professionalism and getting results. We are proud to say that 94% of our 6,000 plus members would recommend us to a colleague.

Health Care Reform Reference Guide

Table of Contents

Section 1
Introduction

Introduction

Welcome to the Associated Industries of Massachusetts (AIM) *Health Care Reform Reference Guide*—an electronic roadmap for employers navigating the Commonwealth's landmark effort to increase access to health insurance. To the best of our knowledge, this Guide is the only one of its kind—written in plain language and designed to provide practical, real-world information and guidance to individuals charged with day-to-day compliance.

AIM is uniquely qualified to assist employers as they endeavor to understand and comply with this complex legislation. Our Government Affairs staff represented the interests of Massachusetts employers throughout the development of health reform legislation and occupied an at-the-table position with the legislature and the state's executive leadership.

Following enactment of the law, AIM's proactive involvement has continued throughout the various regulatory processes and through the appointment, by Governors Romney and Patrick, of our President and CEO, Rick Lord, to represent employers on the Board of Directors of the Commonwealth Health Insurance Connector Authority.

This organizational involvement in the technical aspects of the law allowed our staff of Human Resource professionals to develop exceptional educational materials and programs. AIM quickly became, and continues to be, the "go-to" source of information for employers. We have conducted seminars, briefings, workshops and Webinars for thousands of employers throughout Massachusetts and across the country and have written extensively on the subject of health care reform.

This Reference Guide leads your company step by step through the process of complying with the health care reform law. Are you making a fair share contribution toward the cost of health insurance premiums for your employees? Will your Section 125 plan prevent you from facing a free rider surcharge? What on Earth is a HIRD Form?

This Reference Guide includes:

- AIM-authored "Fact Sheets" that explain in plain English what the government documents mean to you and your company;
- Government documents, including regulations and bulletins, that spell out employer responsibilities;
- Copies of forms that employers and employees will come across; and
- Frequently Asked Questions distilled from months of discussions with employers of all sizes and across virtually all industries and collected from regulatory agencies charged with enforcing the law.

AIM member companies are reminded that our toll-free Employer Hotline is available as a complement to the information provided in the Guide—dial 800.470.6277 for answers to your questions. The same AIM staff members who brought more than 400 years of combined management and human resources experience to bear on developing this Reference Guide also answer your Hotline calls—it's just another example of the "AIM difference."

Associated Industries of Massachusetts

Health Care Reform Programs and Services

AIM can Help:

Information

Educational Programs

Reference Guides

Direct Assistance

Employee Education

800.470.6277
www.aimnet.org

AIM is unsurpassed in its ability to provide information, education, and direct assistance related to compliance issues under this landmark Massachusetts law. Our Government Affairs staff was at the table as the original law and regulations were developed, and they continue to be extremely proactive on behalf of the employers as the law and evolves. Combine this in-depth involvement on the technical policy side with AIM's widely recognized ability to bring highly complex information down to a practical real-world level and it's easy to see why AIM should be your one-stop resource on health care reform issues.

How AIM can Help:

Information

AIM disseminates timely information and detailed analysis through its electronic newsletters, MassBusiness magazine, Website, and online communities.

Educational Programs

AIM's Employer's Resource Group has conducted educational seminars for thousands of employers across the state and across the country. Webinars have also been effectively utilized to convey timely, more narrowly focused information and updates.

Reference Guide

AIM staff authored the *Health Care Reform Reference Guide* as a unique electronic roadmap for information and compliance. The PDF document is thoroughly bookmarked and very easy to navigate. The Guide is designed to familiarize you with virtually all provisions of the law that impact employers and includes copies of all relevant government documents along with interpretive Fact Sheets, Checklists, and frequently asked questions.

Direct Assistance

An AIM HR professional can assist in a number of ways:

- Health Reform Compliance Audit – providing observations and recommendations related to administration of health reform obligations
- Extra Pair of Hands – We can assist you in your compliance efforts or even perform the work on your behalf. We can prepare paper Health 1099 forms, administer HIRD forms, prepare employee communications, assist with open enrollments, etc.

Employee Education – *In Person or Electronically*

- Seminars and Webinars – AIM can come to your company site to conduct educational sessions for your employees. Or we can conduct Webinars specifically for your staff – a great option for multi-site or multi-shift organizations.
- Health Care Reform CD – A 15-minute audio/visual CD designed to educate employees about the Health Care Reform law and its impact on them as individuals and as employees. Generic version can be used in virtually any organization or the product can be customized with your logo and company-specific information for an additional fee. Suitable as a posting on an intranet or given to individuals in CD format.

Please contact Karen Choi: 800.470.6277 | 617.488.8377 | kchoi@aimnet.org

Associated Industries of Massachusetts

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- Hiring Incentive Grant
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- On-Site Training Programs

Professional Networking
- HR Roundtables
- Executive HR Peer Groups
- Plant Manager Roundtable
- CEO Peer Groups

Safety and Health Services
- Safety and OSHA Audits and Inspections
- Development and Implementation of OSHA-Required Programs
- Development and Training of Safety Committees
- Ergonomic Evaluations

Manufacturing Institute
- Lean Manufacturing Training and Implementation
- Training Needs Assessment
- Supervisory and Workforce Training Designed to Support Lean
- Implementation
- Development and Documentation
- Plant Manager Roundtable

Publications
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- Wage and Benefit Surveys
- Employee Applications
- Legislative Directories

For additional information, please contact Karen Choi at 617.262.1180 or kchoi@aimnet.org.

Section 2
Health Care Reform – General Information

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Fact Sheet: Determination of Coverage Under the Law

Fact Sheet: Employers of Fewer than 11 Full-Time Equivalent Employees

Massachusetts Health Care Reform: A Backgrounder on the Landmark Health Insurance Law

Associated Industries of Massachusetts

Fact Sheet

The Massachusetts Health Care Reform Law

Overview of the Massachusetts Health Care Reform Law

Introduction:

Landmark legislation was enacted in April 2006 requiring all residents of Massachusetts, age 18 or older to secure health insurance. The law is built upon the premise of shared responsibility—with the government, individuals, and employers all having key roles and obligations.

Role of the Government:

A new state agency, the Commonwealth Health Insurance Connector Authority (the Connector), was established to connect individuals and small businesses with affordable insurance through private insurers (Commonwealth Choice), and to administer Commonwealth Care, a state-subsidized program available to low-income residents.

Individual Mandate:

All residents of the Commonwealth age 18 and older must have health insurance coverage.
Some important points related to the individual mandate:

- The state will enforce compliance by requiring residents to report on their state income tax forms whether they have maintained health insurance. A break in coverage in excess of 63 days during the tax year is deemed to be a violation of the individual mandate.
- The penalty for non-compliance is 50% of the lowest cost bronze-level plan available through the Connector. Penalties are assessed for each month of non-compliance absent a waiver/exemption approved by the Connector.
- Effective January 1, 2009, each individual must not only have coverage, but must have coverage that meets certain minimum standards called minimum creditable coverage.
- A waiver/exemption from the individual mandate may be requested on the basis of affordability, sincerely held religious beliefs, or serious personal/family hardship. Requests are approved or denied by the Connector and denials may be appealed. An approved waiver allows an individual to be uninsured, or to have coverage that does not comply with minimum creditable coverage standards, without penalty.

Employer Obligations:

All employers, regardless of size, that offer a group health plan insured by a Massachusetts carrier must comply with the new non-discrimination and expanded dependent eligibility rules. Self-insured plans and plans written in other states are not obligated to comply with these rules.

Employers of 11 or more full-time equivalent (FTE) employees must:

1. Offer a compliant Section 125 "premium only" cafeteria plan. Those who fail to do so may be required to pay a "free rider" surcharge if their employees and/or dependents significantly utilize free care.
2. Make a "fair share" contribution toward the cost of health insurance for their employees. Failure to pass a compliance test(s) will result in a "fair share assessment" of up to $295 per FTE employee per year. Compliance is determined through an online filing system administered by the Division of Unemployment Assistance.
3. Administer Employee Health Insurance Responsibility Disclosure (HIRD) forms and submit employer HIRD information through the online fair share compliance filing system.
4. Furnish Form 1099-HC at the end of each tax year to every employee who was covered at any time during that tax year. Duplicate information must be submitted electronically to the Mass. Department of Revenue. Massachusetts insurance carriers are permitted to fulfill this responsibility on behalf of their policyholders and most have chosen to do so. Employers who have self-insured plans or plans written in other states must prepare the 1099-HCs or have them prepared by a third party.

Fact Sheet

The Massachusetts Health Care Reform Law

Determination of Coverage Under the Law

Calculating the Number of Full-Time Equivalent Employees

The employer obligations under the Massachusetts health care reform law generally apply to employers of 11 or more full-time equivalent (FTE) employees.

The formula below is used to calculate the number of full-time equivalent employees an employer has for the applicable determination period. If the number is 11 or more, the employer is subject to all employer obligations under the law. If the number is less than 11, the employer is not subject to the employer obligations.

Formula: $\frac{\text{Total number of payroll hours*}}{2000} = \square$

\# of FTE employees

* ***"Payroll hours"*** *includes regular, overtime, vacation, sick, paid FMLA or other leave, short-term disability, long-term disability, and holidays – i.e., all hours paid – up to a maximum of 2,000 hours for any individual employee in a 12 month determination period. The hours for all individuals employed at a Massachusetts location for more than one month must be included, regardless of where they live. Hours for "temporary" and "seasonal" employees – as defined by the regulations – are not counted. Qualified independent contractors are not counted.*

Employer Requirement	Determination Period**
Section 125 Plan / Free Rider Surcharge Applies to employers with 11 or more full-time equivalent employees.	The determination period is October 1 through September 30 of each year to determine if the employer must comply as of January 1 of the following year.
Fair Share Contribution Applies to employers with 11 or more full-time equivalent employees.	"Fair share year" is always October through September. Effective with the 2008-2009 year, however, employers must comply on a quarter-to-quarter basis instead of for the year as a whole. Accordingly, the quarterly calculation of FTE employees will be based on 500 payroll hours instead of 2,000.
Health Insurance Responsibility Disclosure Forms Applies to employers with 11 or more full-time equivalent employees.	October 1 through September 30 of each year

** ***"Determination Period"*** *refers to the period for which the above calculation must be made to determine if an employer is covered by a provision of the law.*

Associated Industries of Massachusetts

Fact Sheet

The Massachusetts Health Care Reform Law

Employers of Fewer than 11 Full-Time Equivalent Employees

Impact of the Law

Employers of fewer than 11 full-time equivalent (FTE) employees are generally not required to comply with the employer obligations outlined in the health care reform law. It is important to note that it is not necessary to have 11 employees who are called "full-time" in order to have 11 or more FTE employees.

The number of FTE employees is determined according to a calculation that, in simplified terms, is the total number of payroll hours during the applicable determination period divided by 2,000. For Section 125 plans, the determination period is October 1 – September 30 of each year.

For the Fair Share filing, employers must comply on a quarter-to-quarter basis instead of for the year as a whole. Accordingly, the quarterly calculation of FTE employees will be based on 500 payroll hours instead of 2,000.

All employers, regardless of size, who purchase group health insurance in Massachusetts must, however, comply with insurance rules related to expanded dependent eligibility and nondiscrimination in the offer of coverage and amount of premium contribution.

Individuals who work for an employer of fewer than 11 FTE employees are eligible to purchase coverage through the Connector regardless of whether they are offered coverage through their employer.

Employer Considerations

- Consider establishing a Section 125 plan even though you are not required to do so. This allows both you and your employees to realize considerable savings on FICA and/or state and federal income taxes.
- Educate yourself on the employer responsibilities under the law as you approach the threshold for coverage—11 or more full-time equivalent employees. You will then be better able to make informed business decisions.
- If you do not currently offer group health insurance, the requirement that all Massachusetts residents age 18 or older secure insurance could result in increased pressure from current or prospective employees. While there is no legal requirement that any employer offer group insurance, it is recommended that you be prepared to respond to inquiries.
- If you currently offer group health insurance, you may continue to purchase and offer it exactly as you have in the past. Or, as an employer of 50 or fewer employees, you may choose to take advantage of a "group" option through the Connector's Commonwealth Choice program.

Massachusetts Health Care Reform:

A Backgrounder on the Landmark Health Insurance Law

June 2006

AIM Note:
While this document was published in 2006, immediately following the enactment of the health care reform law, it still serves as an excellent overview of the landmark legislation.

Associated Industries of Massachusetts Foundation, Inc.

The Associated Industries of Massachusetts Foundation, Inc. is an educational and economic research organization established by Associated Industries of Massachusetts, the largest nonprofit, nonpartisan organization of employers in the Commonwealth.

The Foundation was created in 1991 to develop in-depth, nonpartisan, fact-based analysis of public policy issues. The Foundation is classified as a Section 501(c)(3) organization under the Internal Revenue Code.

The work of the Foundation is not and should not be construed as an attempt to aid or hinder the passage of any specific legislation before the Congress or the Massachusetts Legislature.

Massachusetts Health Care Reform:
A Backgrounder on the Landmark Health Insurance Law

Associated Industries of Massachusetts Foundation, Inc.
222 Berkeley Street | P.O. Box 763
Boston, MA 02117-0763 | 617-262-1180

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77 Franklin Street, Suite 507
Boston, MA 02110 | 617-574-9282

Introduction

On April 12, 2006, Governor Romney signed into law landmark health care reform legislation that requires all residents to carry a minimum level of health insurance by July 1, 2007.[1]

The health care reform law is groundbreaking. But critical details were deferred. Many key sections of the law will require promulgation of regulations.

A confluence of influences made health care reform happen – the requirement imposed by the federal government to develop an innovative way of covering the uninsured or risk losing millions of dollars in Medicaid reimbursements; the threat of a ballot initiative that would make health care a constitutional right; introduction of an onerous new payroll tax through a ballot initiative; the willingness of all the vested interests in health care to work towards constructive change to the status quo; and the political will of the Governor, Senate President and House Speaker to implement meaningful reform.

Based on a compromise of reform measures contained in separate plans proposed by the Governor, the Massachusetts Senate and House, the law's underlying principle is that the government, employers, and individuals all share responsibility for expanded health care coverage.

While conceptually groundbreaking, the law requires a reorganization of the health care system and many of the implementation details have yet to be determined. Virtually all the key sections of the law will require the promulgation of regulations – involving at least nine different state offices. In addition, the administration and the legislature have both acknowledged that the law may need to be revised through the issuance of technical corrections.

It also remains possible that the statute could be challenged on the grounds that some of the provisions are pre-empted by ERISA – a federal law established in 1974 that sets minimum standards for pension and health plans in private industry.

Sponsored by the AIM Foundation, this paper provides an overview of the health care reform law and AIM's understanding, as a primary negotiator in the process, of provisions where the statutory language is ambiguous or the details are still undetermined. Updates to this paper will be provided as progress is made in the rule-making process. In the interim, employers should review the new law and the many ways it could impact them.

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[1] Chapter 58 of the Acts of 2006 - An Act Providing Access to Affordable, Quality, and Accountable Health Care

Background on Massachusetts Health Care Reform

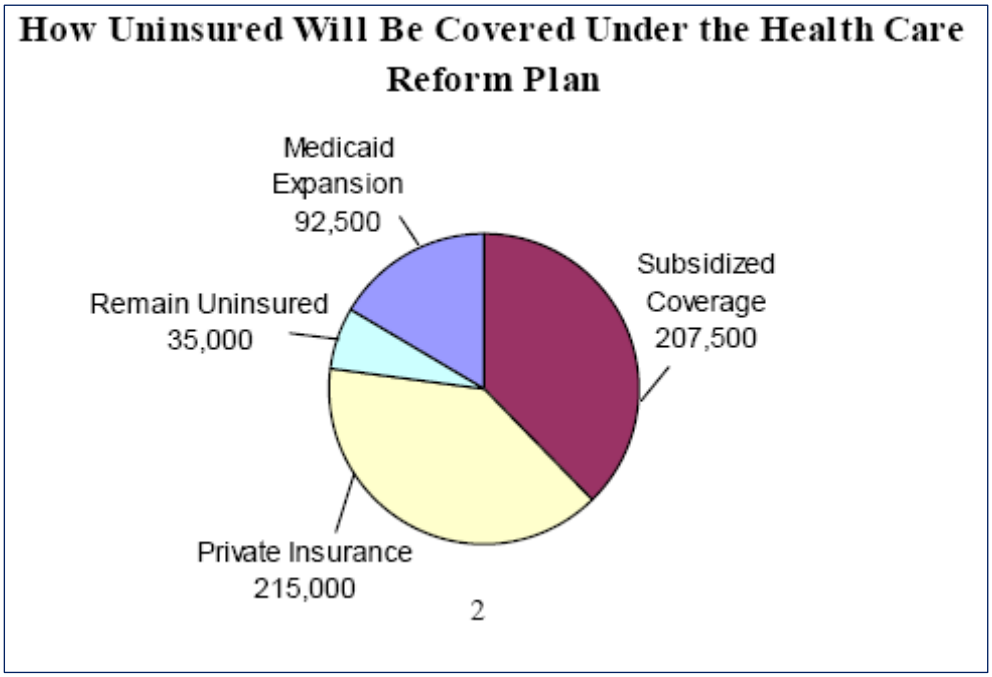
Three contributing factors led to the Massachusetts health care reform law. The most important was a federal requirement to make changes to the state's Medicaid ("MassHealth") Waiver by July 1, 2006 or jeopardize $600 million in federal funds. This required that a new plan for covering the uninsured be developed. Second, rising health care costs were threatening the affordability and accessibility of care. Between 2000 and 2005, family plan premiums in the state increased by almost 50%. Lastly, strong grassroots efforts generated two potential health care reform ballot initiative questions.

The state was well positioned for reform. Compared to other states, the Commonwealth has a relatively low uninsurance rate, ranked 6th in providing coverage to residents. The state also has a strong base of employer coverage as 70% of the state's employers offer employee health insurance. In addition, Massachusetts has a generous Medicaid program and a strong network of safety net providers – community health centers and hospitals that provide care to the uninsured funded by the Commonwealth's Uncompensated Care Pool.

The risk of losing federal funds, skyrocketing health insurance premiums, and the prospect of state ballot initiatives provided incentives for health care reform.

The health care reform law will apply different income-based approaches to assist the state's approximately 550,000 uninsured obtain health insurance:

- Medicaid eligible, but un-enrolled — enroll residents through targeted outreach efforts.
- Not Medicaid eligible, but cannot afford health insurance – provide government subsidy to purchase private insurance.
- Residents who can afford insurance, but choose not to – require the purchase of private insurance.



In summary, the law mandates market reforms to enable the development of affordable private insurance products and aims to eliminate cost shifting by holding individuals and employers responsible for contributing to health care. Federal and state government spending for free care will be redirected to help individuals pay for health insurance. The law will implement health care cost containment measures through the promotion of transparency of comparable provider cost and quality data.

The health care reform law will require significant reorganization, cost shifting and containment. New health care regulations and entities will be developed.

For certain populations, the Medicaid program will be expanded by increasing income eligibility for children, increasing enrollment caps and restoring benefits previously cut. Reimbursements to Medicaid providers will also be increased based on performance goals.

These reforms – most of which will be implemented beginning in 2007 – will require regulatory changes and the formation of several new health care entities. Key components of the law are summarized below and in Table 1.

Reforms to Enable Affordable Insurance Product Development

The statute contains several industry market reforms that will allow private insurers to develop more affordable insurance products:

Reforms will enable insurers to develop more affordable insurance products.

- merge the non- and small-group markets in July 2007 – a provision that is expected to decrease non-group premium costs by 24%. (The resulting bump-up in rates presumed for the small group market will not materialize as more people enter the insurance market as a result of the individual mandate and the risk pool grows);
- allow HMOs to offer high deductible plans that are linked to Health Savings Accounts, reducing costs for those who enroll in such plans;
- 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;
- develop lower-cost specially designed products for 19-26 year olds without access to employer-sponsored coverage that may exclude certain state mandated benefits; and
- allow insurers to rate individuals and small groups based on their smoking status and participation in wellness programs.

Preliminary estimates for "affordable plans" are $200/month. Government subsidized plans would be $30 to $140/month – or free for qualified low-income residents.

In addition, there will be a moratorium on the creation of new health insurance mandated benefits through 2008.

Commonwealth Health Insurance Connector to Facilitate Insurance Purchase

The Commonwealth Health Insurance Connector, a quasi-public independent authority overseen by an appointed board of private and public representatives will serve two critical roles in this health care reform. The first is to "connect" individuals and small businesses with affordable health insurance products developed by private insurers. The Connector will not design insurance products or regulate the insurers offering the plans – the Division of Insurance will continue to perform these functions. Rather, the Connector will facilitate the purchase of authorized health insurance plans by individuals and small businesses by "certifying" insurance plans that offer good value to consumers with a "Seal of Approval". In order to receive this approval, insurance products must meet the requirements for health benefit plans under the small group insurance licensure regulations. The Connector will provide information on such products and arrange for the collection of premium payments beginning in April 2007.

Businesses with 50 or fewer employees will be able to designate the Connector as its group health insurance plan.

Those eligible to purchase insurance through the Connector will include:

- non-working individuals;
- working individuals at companies that do not offer health insurance;
- working individuals not eligible for coverage at their place of business, such as part-timers, contractors and new employees;
- small businesses with 50 or fewer employees; and
- the self-employed.

Employees will be able to take their coverage from job to job. The Connector will ensure that premium payments will be on a pre-tax basis.

Individuals who are employed will be able to purchase insurance through the Connector using pre-tax dollars (through Section 125 "cafeteria" plans set up by their employers), significantly reducing costs to individuals (between 10-40% depending on one's federal tax bracket).

The Connector will provide a "one-stop shop" framework for new insurance products meeting the needs of consumers rather than employers.

The Connector allows for portability of insurance as individuals move from job to job and permits more than one employer to contribute to an employee's health insurance premium. This will allow companies to provide insurance to part-time workers and permits individuals who hold two or more jobs to combine premium contributions from multiple employers. Participating employers will have the ability to determine the eligibility criteria for their employees and the amount of their contribution, if any.

The second function of the Connector will be to administer the new Commonwealth Care Health Insurance product outlined below.

Subsidized Health Insurance for Low-Wage Individuals

A program within the Connector – called the Commonwealth Care Health Insurance Program – will provide government-funded subsidies to low-income individuals to assist with the purchase of health insurance, scheduled to begin October 1, 2006.

Sliding-scale subsidies for low-income residents will be developed by the Connector in consultation with the offices of Medicaid and Health Safety Net.

The Commonwealth Care Health Insurance Program will provide sliding scale subsidies to individuals with incomes above Medicaid eligibility and less than or equal to 300 percent of the Federal Poverty Level (FPL) for the purchase of health insurance ($29,400 for an individual and $49,800 for a family of three). Individuals with incomes less than 100% of the FPL ($9,800 for an individual) will not be required to pay premiums.

Plans offered through Commonwealth Care will have no deductibles. To transition from the current system, subsidized products will be offered exclusively by managed care organizations that participate in the Medicaid program through 2009 (Neighborhood Health Plan, Boston Medical Center Health Net, Cambridge Health Alliance Network and Fallon Community Health Plan).

After 2009, all insurers will be able to offer subsidized insurance products. Benefits in these subsidized plans will be comprehensive, and contain all mandated benefits. The funds currently spent on providing free care in hospitals will be redirected to pay for these subsidies.

An uninsured individual will be eligible to participate in the program if the individual:

- has household income that does not exceed 300% of the federal poverty level;
- has been a resident of the Commonwealth for the previous 6 months;
- is not eligible for any MassHealth, Medicare or child health program;
- or family member's employer has not provided health insurance coverage in the past 6 months for which the individual is eligible and for which the employer covers at least 20% of the annual premium cost of a family health insurance plan or at least 33% of an individual health insurance plan; and
- has not accepted a financial incentive from his employer to decline his employer's health insurance plan.

Individual Mandates

As of July 1, 2007, all residents of the Commonwealth ages 18 and older must have creditable health insurance coverage so long as it is deemed affordable under a schedule set annually by the Board of the Connector. Individuals will be able to challenge the affordability of products on the basis of their unique financial circumstances through a review process established by the Connector. The Connector will make that determination on a case-by-case basis. In cases where health insurance is deemed unaffordable, no penalty will be imposed for failing to obtain insurance coverage.

Requiring individual responsibility allows federal and state monies to be reallocated to subsidize private insurance for low-income workers – subsidizing people not providers.

The state will enforce compliance by requiring residents to report on their state income tax forms whether they have maintained health insurance. Individuals who have not purchased affordable health insurance nor enrolled in an appropriate health insurance program such as MassHealth face the penalty of losing the personal exemption on their state income tax for 2007. For later years, failure to comply with the requirement will result in a penalty of up to 50% of the monthly "minimum insurance premium for creditable coverage" for each month without coverage.

Employer Requirements

Employers with 11 or more employees are required to:

- *Offer Section 125 "premium only" cafeteria plans.* To make insurance more affordable, employers must offer cafeteria plan coverage to their employees, either under their own group health plans or through the Connector – so that employees may purchase health insurance products on a pre-tax basis. (Employers should determine whether any changes to existing cafeteria plans are needed – as a separate plan may be required for employees to purchase insurance through the Connector.)

At a minimum, companies will be required to establish a Section 125 cafeteria plan so employees can purchase insurance with pre-tax dollars. Employers with 10 or fewer employees are exempt from all provisions.

- *Potentially pay a free rider surcharge if Section 125 cafeteria plan not offered.* Employers who fail to establish a Section 125 cafeteria plan to enable their employees to purchase health insurance with pre-tax dollars through the Connector could potentially be subject to a new assessment, called the free rider surcharge, if an employee receives free care more than three times a year or a company has five or more instances of employees receiving free care in a year. The surcharge will range from 10% to 100% of the state's cost of services provided to the employees and their dependents – with the first $50,000 per employee exempted.

- *Potentially make a "Fair Share" contribution if insurance is not offered.* Certain non-providing employers will be required to make payments to the free care pool to cover the cost of providing care to the uninsured. The determination as to "non-providing" is made by a two-part test. Does the employer: (1) offer a qualified plan (2) to which a "fair and reasonable" premium contribution is made? Perhaps the most contentious provision in the new law, AIM worked to make sure it was not onerous for employers. Therefore, there is no requirement that the qualified plan be offered to all employees, or even to all full-time employees. If an employer offers health insurance to a portion of its workers, the employer is not subject to the fair share assessment. For an employer that is subject to the assessment, the amount will be determined by a formula, not exceeding $295, multiplied by the total number of full-time employee equivalents (defined as 2000 hours worked). The amount of the assessment is tied to the usage of the free care pool, and is expected to diminish considerably over time.
- *Administer Health insurance Responsibility Disclosure Forms.* Compliance will require the generation and administration of more record-keeping as employers and employees will have to complete annual disclosure forms indicating whether the employer has offered to pay for or arrange for the purchase of health care insurance for its employees and whether the employee has accepted or declined such coverage.

Part of the uncompensated care pool is paid by businesses via a surcharge on private insurance ~ $62/worker/year. The $295 assessment fee requires companies that do not offer insurance to contribute.

Companies will administer disclosure forms – as well as potential revisions to antidiscrimination policies.

In addition, employers will be prohibited from discriminating against an employee if free care is received (i.e., free rider surcharge) – this may require revision of employer anti-discrimination policies, etc.

Medicaid Eligibility and Program Expansion

MassHealth eligibility will be extended to children in families earning up to 300 percent of the FPL ($49,800 for a family of 3). Enrollment caps on existing MassHealth programs for adults will also be raised, including MassHealth Essential (additional 16,000 people), HIV program (additional 250 people), and CommonHealth (additional 1,600 people). In addition, MassHealth benefits that were cut in 2002 will be restored (dental, vision, chiropractic, prosthetic services).

Increasing Medicaid reimbursement rates is beneficial. When reimbursements fall short, the difference is reflected in higher insurance premiums paid by employers.

In response to concern that Medicaid has underpaid many of its providers in the past, the bill sets aside $90 million in increased provider payments for FY2007, $180 million for FY 2008 and $270 million in FY 2009. Such increases are tied to performance goals and will be dependent upon hospitals meeting quality improvement goals as determined by the Executive Office of Health and Human Services. The law also requires

Medicaid to develop pilot programs for smoking cessation and a wellness program that encourages enrollees to participate.

Elimination of Uncompensated Care Pool

On October 1, 2007, the Uncompensated Care Pool will be eliminated and replaced with the Health Safety Net Fund – which will be administered by a newly created Health Net Safety Office (HSN) located within the Office of Medicaid. The purpose of the Fund will remain the same – to maintain a health care safety net by reimbursing hospitals and community health centers for a portion of the cost of services provided to low-income, uninsured or underinsured residents. The HSN Office will develop a new standard fee schedule for hospital reimbursements, replacing the current payment system. It is anticipated that as free care use declines due to higher insurance coverage required by the law, funds from the Health Safety Net Fund will be transferred to the Commonwealth Care Health Insurance Program.

New Cost and Quality Measures

A Health Care Quality and Cost Council will be created to set quality improvement and cost containment goals. The Council will reside in the Executive Office of Health and Human Services, but will be governed by a board consisting of public and private members. It will be responsible for collecting cost and quality data from health care providers and for developing and maintaining a consumer website. These efforts will provide greater transparency and accountability on the part of providers and will better inform consumer choices. Insurers will have to submit data to the Council as required by regulations to be promulgated. Financial penalties will be assessed, up to $50,000, for failure to report data in a timely manner.

Availability of cost data by provider will increase competition and lower costs. Consumers will have information to choose high quality, lower cost health care.

Reform Funding – Leading to Cost Containment and Reduction

Funding for health care reform will come from a variety of sources – most of which will result from redirecting funds currently spent on free care through the Uncompensated Care Pool (about $1 billion), which is funded from a combination of hospital, insurer, and state and federal funds. No new taxpayer funds have been determined to be needed – however $200 million from the general revenues will be used for the initiative. Moreover, significant new revenue is expected from the premium dollars spent by those entering the insurance market for the first time as a result of the individual mandate. The Commonwealth must obtain approval from the federal government for any payments and payment methodologies using federal funds. The federal government is expected to approve the state's health care reform plan before July 1, 2006.

Once the reform measures are implemented, employers should expect to see some health care cost stabilization — and eventual reduction as the changes to the marketplace evolve.

Looking Ahead

The enactment of the bipartisan health care reform bill was a significant accomplishment. Properly implemented, it will expand coverage, provide greater consumer choice, contain rising health care costs and promote competition among insurers and providers. Despite the national headlines the legislation has attracted, its success will largely depend on the details yet to be worked out.

On behalf of its members, AIM will continue to work with lawmakers to clarify details as they emerge and participate in the rule making process. Updates and their implications will be provided as progress is made.

Over the next few months, AIM will continue to advocate on behalf of its members to ensure regulations are promulgated and details fleshed out in the best interest of the business community.

Employers should become familiar with the proposed changes to the Commonwealth's health care system and pay close attention to rules and details as they emerge, particularly concerning:

- *Commonwealth Health Insurance Connector:* how it is structured, the process for purchasing insurance for employees, and how to establish a Section 125 cafeteria plan that permits employees to purchase health care through the Connector with pre-tax dollars.
- *Employer Requirements:* how the "fair share contribution" will be determined – what the employer payment to the free care pool will be if a "qualified plan" is not offered to which a "fair and reasonable" premium contribution is not made.
- *Employer Compliance Procedures:* the disclosure rules to demonstrate whether employers have offered to pay for or arrange for the purchase of health care insurance for employees and whether employees have accepted or declined such coverage.

Table 1: Key Provisions of Massachusetts Health Care Reform

Health Care Reform Provision	General Description	Key Known Uncertainties
Market Reforms ▪ Merger of non- and small-group markets ▪ Extended coverage for young adults ▪ (family policies for up to age 25) ▪ Special products for ages 19 thru 25 ▪ High deductible health plans (HDHP) offered in conjunction with a Health Savings Account	Will enable private insurers to develop affordable health insurance benefits to small businesses and individuals	Actuarial study of market merger to be performed Raises questions about existing approved HDHPs by the Mass Division of Insurance that are not offered in conjunction with HSAs Young adult plan regulations needed
Commonwealth Health Insurance Connector* ▪ Permits private insurers to offer new affordable policies to small businesses and individuals ▪ Reduces cost through pre-tax treatment of premium contributions	Will connect individuals and eligible small groups with health insurance products that have been certified with a "seal of approval", allows portability of insurance, facilitates employer contributions for individuals working part-time or for more than one employer	Rules to be established for new low-cost health insurance products including required basic coverage and premiums. Definition of "affordable" to be established Connector board/staff to be established
Commonwealth Care Health Insurance* ▪ Redirect funds currently spent on providing free care in hospitals toward subsidizing health insurance	A subsidized program operated through the Connector for low-income individuals. Premiums will be on sliding scale based on household income	Eligibility standards for health insurance subsidies to be established
Individual Mandates ▪ Promotes personal responsibility	Requires residents ages 18 and older to carry health insurance, as long as affordable coverage is available	A sliding "affordability" scale to be set annually by the Board of the Connector to be established
Employer Responsibility ▪ Encourage contribution toward coverage	Offer Section 125 cafeteria plan, Make "fair and reasonable" contribution, Free Rider Surcharges	Definition of "fair and reasonable" to be established
Medicaid Expansion*	Increase eligibility, and reimbursement to hospitals	Hospital quality improvement goals to be determined
Uncompensated Care Pool Elimination*	Replaced with Health Safety Net Fund	Health Net Safety Office to be created and payment rules to be developed
Cost and Quality Programs*	Collect cost and quality data from health care providers and disseminate to consumers for greater accountability and to influence consumer behavior	Health Care Quality and Cost Council to be created. Types of data/ methods of collection to be defined

Section 3

The Individual Mandate, Minimum Creditable Coverage, and Affordability

Fact Sheet: The Individual Mandate

Fact Sheet: Minimum Creditable Coverage

Fact Sheet: Affordability of Health Insurance in Massachusetts

Minimum Creditable Coverage Final Regulations

Connector Administrative Bulletin 01-08: Guidance Regarding Minimum Creditable Coverage Certification On and After January 1, 2009

Minimum Creditable Coverage Certification Application

Division of Insurance Bulletin 2008-02: Requirements for Disclosure of Minimum Creditable Coverage

Department of Revenue TIR 09-01: Individual Mandate Penalties for Tax Year 2009

Form MA 1099-HC

2008 Schedule HC

2008 Massachusetts Schedule HC Health Care: Instructions and Worksheets

Associated Industries of Massachusetts

Fact Sheet

The Massachusetts Health Care Reform Law

The Individual Mandate

Administrative Agencies: Massachusetts Department of Revenue and The Connector

Effective Date: December 31, 2007

Individual Mandate

Effective December 31, 2007, all residents of the Commonwealth age18 and older must have health insurance coverage unless they are granted a waiver/exemption by the Connector. Beginning with tax year 2009, that coverage must meet the regulatory definition of "minimum creditable coverage." Compliance with the individual mandate is automatic for those with certain coverage, i.e., Medicare Part A, MassHealth, and Tricare, as well as those registered to receive services under the U.S. Veterans Administration.

Waiver/Exemption Criteria

The Connector may grant a waiver on the basis of affordability, sincerely held religious beliefs, or serious personal/family hardship. Granting of a waiver enables an individual to go without insurance coverage for a given year without penalty. The waiver does not make the individual eligible for MassHealth, Commonwealth Care, or any other government-paid or government-subsidized program. The Connector's decision to deny a waiver can be appealed.

Compliance

The Department of Revenue (DOR) is responsible for enforcement of the Individual Mandate and compliance is determined through Schedule HC of the individual income tax return. Individuals who receive a Form 1099-HC will transfer information from that form. Others must collect requested information from other sources. The waiver/exemption request process is also initiated through the Schedule HC when individuals indicate that their lack of coverage is due to affordability, sincerely held religious beliefs, or personal/family hardship. A copy of the most recent Schedule HC and instructions are included in this section.

Penalties for Non-Compliance

Individuals who have not obtained insurance, or who go without coverage for any period longer than 63 days, will face a tax penalty for each month of non-compliance. The penalty is up to 50% of the cost of the least expensive Bronze-level plan offered by the Connector. For tax year 2008, the individual penalty ranged from zero to $912 for an entire year without coverage. As reflected in the DOR's TIR 09-1, penalties for the 2009 tax year will be from zero to $1,068. TIR 09-1 is included in this section. The penalties will be adjusted each year according to changes in the Bronze-level premiums.

Affordability

An individual's ability to afford insurance coverage is determined according to predetermined "affordability schedules" based on annual adjusted gross income of an individual, a married couple without dependents, or a married couple or head of household with dependents. The schedules present income ranges and the amount of monthly premium that is deemed affordable for each range. The schedules are reviewed and potentially adjusted each year by the Connector Board of Directors.

Associated Industries of Massachusetts

Fact Sheet

The Massachusetts Health Care Reform Law

Minimum Creditable Coverage

Status of Regulations: Final

Administrative Agency: The Connector

Effective Date: October 31, 2008

General Purpose of Minimum Creditable Coverage

Minimum creditable coverage (MCC) establishes the lowest threshold health benefit plan that an individual must have in order to satisfy the legal requirement that a Massachusetts resident have health coverage. This means that individuals who have no coverage, or who have coverage that does not meet MCC standards, will not comply with the individual mandate and will, absent an approved exemption, be liable for income tax penalties for each month of non-compliance.

Impact on Employers

Although MCC is an obligation of individual Massachusetts residents, there is an indirect impact on employers since individuals covered under a non-compliant group plan will be out of compliance with the individual mandate unless they arrange for coverage to fill the gaps. Most employers would not choose to have their employees placed in this position.

There is one direct obligation on employers, however, that arises from the MCC rule. Employers are required to issue a Form 1099-HC following the end of each tax year to every employee who was covered under their group health plan(s) at any time during that year. The 1099-HC lists all individuals who had coverage, including dependents, and their dates of coverage during the year. Beginning with the 2009 tax year, they must also indicate whether or not the coverage complies with MCC. This means that employers must determine and report the MCC compliance of their group health plan(s). The Connector's Administrative Bulletin 01-08 was issued in November 2008 to provide guidance for this determination.

Key points from Administrative Bulletin 01-08 (copy included in this section):

- **First Step = Self-assessment** - The Connector expects employers to conduct a self-assessment to determine whether their employer-sponsored plan(s) meet the MCC standards set forth in the regulations. Multiple plans should be aggregated when conducting this assessment. **If compliance is confirmed, as is expected to be the case for a large majority of employers, no further action is required.**
- **Plans Insured by Mass. Carriers –** Under the Division of Insurance Bulletin 2008-02 (copy included in this section), Mass. insurance carriers are required to disclose whether or not a plan complies with MCC. Employers that offer a plan insured by an in-state carrier should simply contact the carrier, or broker, if this required disclosure information is not readily located.

- **MCC Certification by the Connector –** The Connector has the authority, in its sole discretion, to deem a plan compliant with MCC when that plan does not meet every element set forth in the regulations but the overall value of the benefits provides "sufficiently comprehensive" coverage. If an employer believes this to be the case with its plan(s), a Connector review may be requested through submission of the "MCC Certification Application" (copy in this section). If the information requested through the application proves to be insufficient, the Connector may request additional information from the applicant. The Bulletin gives several examples of when this certification request might be in order.
- **Aggregating Multiple Plans –** When coverage is provided through multiple plans, the combined benefits of those plans should be considered when conducting the self-assessment. Likewise, when applying for Connector certification of coverage provided under multiple plans, information about each separate plan must be submitted with the application.
- **Actuarial Attestation –** The Connector reserves the right to require a certification applicant to provide an actuarial analysis of a plan in order to make a final determination of whether the value of the plan's benefits is equal to or greater than any bronze-level plan offered through the Connector. But the actuarial attestation is not required with the initial application.
- **Collectively Bargained Plans –** A collectively bargained, or a multi-employer plan, that is in effect on January 1, 2009, and is unable to confirm MCC compliance through self-assessment, may apply for MCC certification through the Connector. The agency has the authority to grant certification within special parameters set forth in the regulations, although the safe harbor is not automatic. Significant detail is contained in the regulations and administrative bulletin.

Highlights of the Minimum Creditable Coverage Regulations

The regulations (copy included in this section) contain significant detail in defining MCC. Key highlights:

- Plan must provide coverage for all core services, defined as physician services, inpatient acute care services, day surgery and diagnostic services.
- Plan must also provide some level of coverage for each of the broad range of medical benefits listed in the regulations. There are two lists of such services – one effective January 1, 2009, which includes prescription drug coverage, and an expanded list that is effective January 1, 2010.
- There can be no annual or per-illness maximum on core services although such limits are permissible for other types of service.
- Deductibles for in-network covered services cannot exceed $2,000 for an individual and $4,000 for a family.
- Out-of-pocket maximums for in-network deductibles, co-payments and co-insurance may not exceed $5,000 for an individual and $10,000 for a family.

- At least three preventive care visits for an individual per year, or six per family per year must be exempt from any deductible. Co-payments may apply, however.
- Prescription drug coverage must be provided and can have a deductible of no more than $250 for an individual or $500 for a family.
- Coverage provided by multiple plans may be aggregated when determining compliance with MCC.
- High deductible health plans (HDHP) that comply with federal requirements for health savings accounts will comply with minimum creditable coverage for 2009. Effective 2010, some new rules apply for HDHP compliance.

- The revised final regulations create a potential safe harbor for plans that do not meet the letter of MCC but that are deemed, by the Connector in its sole discretion, to provide, overall, sufficiently comprehensive benefits. Plans must apply for Connector certification using the process set forth in Administrative Bulletin 01-08. If the Connector is unable to make a decision based on the information submitted with the application, an actuarial evaluation of the plan(s) may be required, at the applicant's expense. Generally, a plan with benefits that have an actuarial value that is at least equivalent to that of any bronze-level plan offered through the Connector will be deemed compliant with MCC.

- A second safe harbor provision was created for collectively bargained plans and multi-employer plans that were in effect on January 1, 2009 and for which MCC compliance is not easily determined through self-assessment or through a disclosure by a Massachusetts carrier. The Connector, again in its sole discretion, may certify MCC compliance for up to one year following the expiration of the current collective bargaining agreement. Details are contained in the regulations and in Administrative Bulletin 01-08. The application process is virtually the same as that described in the above bullet.

Affordability of Health Insurance in Massachusetts

Administrative Agency: The Connector

Effective Date: July 1, 2007

A cornerstone of the Massachusetts health care reform law is the availability of "affordable" insurance products. Effective December 31, 2007, the individual mandate requires state residents age 18 or older to have health insurance. In general, individuals may request a waiver from this obligation only on the basis of sincerely held religious beliefs (sworn affidavit is required), serious personal or family hardship, or on the basis of affordability. An approved waiver means that an individual may remain uninsured without being subject to penalty. It does not make an individual eligible for any government-paid or government-subsidized program for which he/she is not otherwise eligible.

In order to evaluate waiver requests, the Connector was charged with the complex task of establishing the definition of "affordability." As a result, the Connector board of directors adopted schedules for determining affordability based on income levels for:

1. Individuals
2. Married couples with no dependent(s)
3. Heads of household or married couples with dependent(s)

The schedules are based on annual adjusted gross income and specify the maximum monthly amount deemed affordable for a specific range of income. Family size, i.e., total number of dependents, will also be taken into account, as will geographic differences in premium costs.

Waiver requests may be based upon the amount an employee is required to contribute toward coverage offered through an employer, or may be based upon the cost of insurance in the general marketplace – whichever applies to the individual. Connector decisions will be based upon the lowest-cost coverage available to the individual.

Affordability schedules are reviewed, and potentially adjusted, each year by the Connector board of directors.

Affordability Schedules for 2009 have been proposed but not finalized as of the date this Guide was published. Please consult the Connector's Web site (www.mahealthconnector.org) to obtain the finalized schedules.

Final Version 10-31-08.

956 CMR: COMMONWEALTH HEALTH INSURANCE CONNECTOR AUTHORITY

956 CMR 5.00 MINIMUM CREDITABLE COVERAGE

Section

5.01: General Provisions

Scope and Purpose. 956 CMR 5.00 establishes the criteria for the lowest threshold health benefit plan that an individual must purchase in order to satisfy the legal requirement that a Massachusetts resident have health coverage that constitutes minimum creditable coverage so as to avoid paying a penalty to the Department of Revenue pursuant to M.G.L. c. 111M, §2. Minimum creditable coverage is designed to provide individuals (and dependents) purchasing the coverage with financial access to a broad range of health care services, including preventive health care, without incurring severe financial losses as a result of serious illness or injury.

5.02: Definitions.

As used in 956 CMR 5.00, the following words shall have the following meanings, except where the context clearly indicates otherwise:

Ambulatory Patient Services. All outpatient services regardless of the setting.

Annual Maximum Benefit. A maximum amount that a health benefit plan will pay per year for covered services for an individual or family.

Co-insurance. A percentage of the allowed charge, after a co-payment, if any, that a covered person will pay for covered services received under a health benefit plan.

Connector. The Commonwealth Health Insurance Connector Authority.

Connector Board. The Board of the Connector established by M.G.L. c. 176Q, § 2(b).

Co-payment. A fixed dollar amount paid by a covered person to a physician, hospital, pharmacy, or other health care provider at the time the covered person receives covered services.

Core Services. Physician services, inpatient acute care services, day surgery, and diagnostic procedures and tests.

Covered Person. An individual who is covered under a health benefit plan.

Covered Services. The healthcare services, supplies and drugs that are paid for under the health benefit plan.

Deductible. An annual dollar amount that must be paid by a covered person for specified health care services that a covered person uses before the health benefit plan becomes obligated to pay for covered services. Some health benefit plans may include separate prescription drug deductibles. The deductible amount does not include the premiums that a covered person pays.

Health Benefit Plan. Any individual, general, blanket or group policy of health, accident and sickness insurance issued by an insurer licensed under MGL c. 175; a group hospital service plan issued by a non-profit hospital service corporation under MGL c. 176A; a group medical service plan issued by a non-profit medical service corporation under MGL c. 176B; a group health maintenance contract issued by a health maintenance organization under MGL c. 176G; coverage for young adults health insurance plan under MGL c. 176J, § 10; any self-funded health plan, including a self-funded health plan which is an ERISA "employee welfare benefit plan" providing medical, surgical or hospital benefits, as that term is defined in 29 U.S.C. § 1002; and any individual, general, blanket or group policy of health, accident and sickness insurance issued in any state within the United States of America other than the Commonwealth of Massachusetts by an insurer that is licensed or otherwise statutorily authorized to transact business in such other state.

Indemnity Schedule of Benefits. A fixed dollar amount per service, set forth in the subscriber's certificate of coverage as the maximum amount that a health plan is required to pay to the beneficiary or to reimburse the provider of that service.

Multi-employer Health Benefit Plan. A health benefit plan to which more than one employer is required to contribute, which is maintained pursuant to one or more collective bargaining agreements between one or more employee organizations and more than one employer, and there is evidence that such employer contributions to the Multi-employer Health Benefit Plan were the subject of good faith bargaining between such employee representatives and such employers.

Out-of-pocket Maximum. The annual dollar limit that a covered person will pay for covered services under a health benefit plan, not including premiums.

Premium. A monthly payment made by, or on behalf of, a covered person to purchase and maintain a health benefit plan, regardless of whether the covered person uses health care services or not.

Preventive Care. Covered services provided by a health benefit plan including, but not limited to, routine adult physical exams, well baby care, prenatal maternity care, medically necessary child or adult immunizations, and routine GYN exams.

Resident. As defined in M.G.L. c. 111M, § 1.

5.03: Minimum Creditable Coverage.

(1) For the period beginning on July 1, 2007 and ending on December 31, 2008, the following shall be deemed to provide minimum creditable coverage:

(a) any health benefit plan; and
(b) any health benefit coverage defined as "creditable coverage" in M.G.L. c. 111M, § 1(b) through (l).

(2) For the period beginning on January 1, 2009, a health benefit plan, or the aggregate of multiple health benefit plans, shall be considered as providing minimum creditable coverage if the following requirements of 956 CMR 5.03(2)(a) through (h) are satisfied:

(a) A health benefit plan provides core services and a broad range of medical benefits, in accordance with at least the minimum standards set by state and federal statutes and regulations governing the particular health benefit plan.
    1. Effective January 1, 2009, "a broad range of medical benefits" shall include, at a minimum, coverage for:
        i. Preventive and Primary care
        ii. Emergency services
        iii. Hospitalization
        iv. Ambulatory patient services
        v. Prescription drugs
        vi. Mental health and substance abuse services
    2. Effective January 1, 2010, "a broad range of medical benefits" shall include, at a minimum, coverage for:
        i. Ambulatory patient services, including outpatient, day surgery and related anesthesia
        ii. Diagnostic imaging and screening procedures, including x-rays
        iii. Emergency services
        iv. Hospitalization (including at a minimum, inpatient acute care services which are generally provided by an acute care hospital for covered benefits in accordance with the member's subscriber certificate or plan description)
        v. Maternity and newborn care
        vi. Medical/surgical care, including preventive and primary care
        vii. Mental health and substance abuse services
        viii. Prescription drugs
        ix. Radiation therapy and chemotherapy

(b) A health benefit plan may impose reasonable exclusions and limitations, including different benefit levels for in-network and out-of-network providers.

For a health benefit plan that does not have a network design, the overall health benefit plan design must meet the requirements of 956 CMR 5.03(2) to be considered as providing minimum creditable coverage.

(c) A health benefit plan may impose varied levels of co-payments, deductibles and co-insurance, provided that:
   1. 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;
   2. any deductible for in-network covered services shall not exceed $2,000 for an individual and $4,000 for a family; and
   3. any separate deductible imposed for prescription drug coverage shall not exceed $250 for an individual and $500 for a family.

(d) If a health benefit plan includes deductibles or co-insurance for in-network covered core services, 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. If the health benefit plan's out-of-pocket maximum is defined without inclusion of the deductible, a health benefit plan will satisfy the provisions of 956 CMR 5.03(2)(d) if the plan's out-of-pocket maximum for in-network covered services, when combined with the plan's deductible for in-network covered services, does not exceed $5,000 for an individual and $10,000 for a family.

(e) A health benefit plan's calculation of any out-of-pocket maximum must include all the following payments for in-network 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.

(f) A health benefit plan:
   1. may not impose an overall annual maximum benefit limitation for the plan that applies to all covered services collectively;
   2. may not impose an overall annual maximum benefit limitation based on dollar amount or utilization that caps covered core services, whether individually or collectively, for a year or for any single illness or condition;
   3. may apply maximum benefit limitations to services that are not considered core services, as defined by 956 CMR 5.02. However, the Connector, in its discretion, may determine that, for the period beginning January 1, 2010, a health benefit plan does not meet the standards for minimum creditable coverage if:
      a. the maximum benefit limitations established by the health benefit plan are clearly inconsistent with standard employer-sponsored coverage; and

b. the maximum benefit limitations established by the health benefit plan do not represent innovative ways to improve quality or manage the utilization or cost of services delivered.

4. Examples of limitations that are allowed include, but are not limited to, the following:
    a. benefit limits on substance abuse treatment to the extent consistent with federal law.
    b. benefit limits on physical therapy.
    c. benefit limits on inpatient rehabilitation care services.
    d. benefit limits on durable medical equipment, or DME.

(g) For the coverage of core services, a health benefit plan may not limit its contractual commitment to the subscriber to an Indemnity Schedule of Benefits. Nothing in this clause is intended to prohibit carriers from agreeing with providers to fee schedules as a basis for reimbursement for their services, from employing reasonable and customary fee schedules as a basis for reimbursing subscribers or providers, or from otherwise devising provider payment methodologies.

(h) A health benefit plan that imposes a deductible for in-network covered core services must cover preventive care services on an annual basis before imposing a deductible. Any preventive care visits covered before the imposition of a deductible may be subject to co-payments or co-insurance, provided, however, that such co-payments or co-insurance shall be no greater than the co-payment or co-insurance applied by the health benefit plan to primary care or routine physician office visits. A health benefit plan will satisfy the provisions of 956 CMR 5.03(2)(h) if as part of the health benefit plan's formal benefit design, the plan provides coverage for preventive care in full accordance with either 956 CMR 5.03(2)(h)1 or 956 CMR 5.03(2)(h)2:

1. The plan covers three (3) for an individual and six (6) for family preventive care visits annually to a physician or other health care provider; or
2. The plan covers preventive care in accordance with nationally recognized preventive care guidelines that are comparable to the Massachusetts Health Quality Partners' (MHQP) Preventive Care recommendations and guidelines, including recommendations and guidelines for adult, pediatric, and prenatal preventive care.

(i) Under 956 CMR 5.03(2), "the aggregate of multiple health benefit plans" may be used to satisfy the requirements of 956 CMR 5.03(2)(a) through (h). A health benefit plan that does not meet the standards for minimum creditable coverage under 956 CMR 5.03(2)(a) through (h) on its own may be combined with additional health benefit plans so that, together in the aggregate, the combined health benefit plans (the net result thereof) satisfy 956 CMR 5.03(2)(a) through (h). For purposes of aggregating multiple health benefit plans under 956 CMR 5.03, the following are examples of permissible aggregations:

1. A health benefit plan that excludes prescription drug coverage may be combined with a separate prescription drug only health benefit plan so that, together in the aggregate, the combined health benefit plans satisfy 956 CMR 5.03(2)(c)3.
2. A health benefit plan that excludes coverage for mental health services may be combined with a separate mental health carve-out so that, together in the aggregate, the combined health benefit plans satisfy the standards of minimum creditable coverage.

(j) A health benefit plan with deductibles exceeding 956 CMR 5.03(2)(c)2 and/or out-of-pocket maximums for in-network covered services exceeding 956 CMR 5.03(2)(d) may be combined with a health reimbursement arrangement, or HRA, so that, together, the "net" deductible amount (i.e., the annual deductible less the annual HRA funding) and out-of-pocket maximum of the combined health benefit plans satisfy 956 CMR 5.03(2)(c)2 and (d).

(k) A health benefit plan with deductibles exceeding 956 CMR 5.03(2)(c)2 and/or out-of-pocket maximums for in-network covered services exceeding 956 CMR 5.03(2)(d) shall be deemed to meet the minimum creditable coverage standards so long as:
   1. For calendar year 2009 only, a health benefit plan is a high deductible health plan ("HDHP") that complies with federal statutory and regulatory requirements for HDHPs under 26 U.S.C. § 223 (i.e., HSA-compatible).
   2. For the period beginning on January 1, 2010, a health benefit plan is a high deductible health plan which
      a. complies with federal statutory and regulatory requirements under 26 U.S.C. § 223; and
      b. complies with 956 CMR 5.03(2)(a), (f), (g), and (h) (to the extent the requirements of 956 CMR 5.03(2) are not inconsistent with federal statutory and regulatory requirements for an HDHP under 26 U.S.C. § 223); and
      c. the carrier or plan sponsor facilitates access to an HSA administrator (i.e., financial institution) to enable a policy holder to establish and fund an HSA in combination with a federally compliant HDHP.

(3) Notwithstanding any other requirement under 956 CMR 5.03, the following shall be deemed to provide minimum creditable coverage:
(a) a Young Adult Plan as defined in MGL c. 176J, § 10;
(b) any health benefit coverage defined as "creditable coverage" in M.G.L. c. 111M, § 1(b) through (l);
(c) any health arrangement provided by established religious organizations comprised of individuals with sincerely held beliefs;
(d) Commonwealth Care Health Insurance plans as established by M.G.L. c. 118H;
(e) any currently operating U.S. Veterans Administration healthcare program administered by the U.S. Veterans Administration;

(f) any health plan offered or approved by the Corporation for National and Community Service for members of the AmeriCorps National Service Network (i.e., AmeriCorps State, AmeriCorps National, Volunteers in Service to America (VISTA), and National Civilian Community Corps (NCCC)), pursuant to the Domestic Volunteer Service Act (42 U.S.C. 4950 *et seq*.) or the National and Community Service Act (42 U.S.C. 12501 *et seq*.); and

(g) a health benefit plan that does not meet every element of minimum creditable coverage required under 956 CMR 5.03(2), but which the Connector, in its discretion, has determined:

1. conforms with the regulatory requirements under 956 CMR 5.00 relating to core services (without limitation) and a "broad range of medical benefits"; and
2. does not fail the standards of minimum creditable coverage established in 5.03(2)(f)(3); and
3. has an actuarial value equal to or greater than any Bronze-level plan offered through the Connector as certified by an actuary.

(4) A group health plan that is maintained pursuant to a collective bargaining agreement in effect on January 1, 2009 may be deemed, in the Connector's discretion, to meet minimum creditable coverage for a period not to exceed one year following the expiration date of the collectively bargained agreement that is in effect on January 1, 2009 or, if part of a Multi-employer Health Benefit Plan , one year following the date of the last renewing collectively bargained agreement that is part of the Multi-employer Health Benefit Plan.

(5) The following shall not be considered to be providing minimum creditable coverage: a plan issued as a supplemental health insurance policy including, but not limited to, accident only, credit only, or limited scope vision or dental benefits if offered separately; hospital indemnity insurance policies if offered as independent, non-coordinated benefits which shall mean policies issued under M.G.L. c. 175 which provide a benefit not to exceed $500 per day, as adjusted on an annual basis by the amount of increase in the average weekly wages in the commonwealth as defined in M.G.L. c. 152, § 1, to be paid to an insured or a dependent, including the spouse of an insured, on the basis of a hospitalization of the insured or a dependent; disability income insurance; coverage issued as a supplement to liability insurance; specified disease insurance that is purchased as a supplement and not as a substitute for a health plan and that meets any requirements the commissioner of insurance, by regulation, may set; insurance arising out of a workers' compensation law or similar law; automobile medical payment insurance; insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in a liability insurance policy or equivalent self insurance; long-term care if offered separately; coverage supplemental to the coverage provided under 10 U.S.C. §55 if offered as a separate insurance policy; or any policy subject to chapter 176K or any similar policies issued on a group basis, including Medicare Prescription drug plans.

5.04: Administrative Bulletins

The Connector may periodically issue administrative bulletins containing interpretations of 956 CMR 5.00 and other information to assist compliance under 956 CMR 5.00.

5.05: Severability.

The provisions of 956 CMR 5.00 are hereby declared to be severable. If any section of portion of sections 956 CMR 5.00, or the applicability thereof to any person or circumstances, is held invalid by any court of competent jurisdiction, the remainder of 956 CMR 5.00, or the applicability thereof to other persons or circumstances, will not be affected thereby.

REGULATORY AUTHORITY

956 CMR 5.00: M.G.L. c. 111M, § 1 and M.G.L. c. 176Q, § 3.

Administrative Bulletin 01-08:

Guidance Regarding Minimum Creditable Coverage (MCC) Certification
On and After January 1, 2009

November 25, 2008

The purpose of this Administrative Bulletin is to provide guidance regarding certain provisions of the Commonwealth Health Insurance Connector Authority's ("Connector") Minimum Creditable Coverage ("MCC") regulation 956 CMR 5.00 ("Regulation").

What are an employer's obligations?

Under the Massachusetts Health Care Reform Law, employers and plan sponsors are not required to provide coverage that meets the Connector Board's MCC standards. However, employers, plan sponsors and carriers are required to provide a written statement, known as a 1099-HC, annually to each subscriber or covered individual residing in the Commonwealth to whom they have provided minimum creditable coverage in the previous calendar year. Therefore, carriers, employers, and plan sponsors will need to determine if their health benefit plans satisfy the MCC standards. In addition, carriers are required to disclose the MCC status of their fully insured health benefit plans sold in the Commonwealth of Massachusetts. Self-insured plans and fully insured plans that are not sold in Massachusetts, on the other hand, are not required to provide such an MCC disclosure.

Self-assessment.

The Connector expects that carriers, employers, and plan sponsors will self-assess and determine whether their plans meet the MCC standards set forth in the Regulation. If you determine that your plan meets MCC standards set forth in the Regulation, you do not need to seek any form of approval or certification from the Connector. The majority of health benefit plans will fall into this self-assessment category.

MCC Certification by the Connector.

The Regulation (956 CMR 5.03(3)(g)) provides the Connector with discretion to deem health benefit plans that deviate modestly from the MCC standards as providing minimum creditable coverage if the plans can demonstrate they meet certain criteria. This process will be referred to as MCC Certification and is designed to provide plans a way to comply with MCC standards in instances in which a plan does not meet every element of the Regulation. An employer, plan sponsor, or carrier seeking to have a plan deemed MCC compliant via this alternative to self-assessment must complete an MCC Certification Application.

The Connector's MCC Certification Application requests information that the Connector believes is necessary to make a determination on the Application as expeditiously as possible. In cases where the Connector does not receive sufficient information with the Application, the Connector will request additional information so that it has the necessary information with which to make a determination.

An applicant for MCC Certification must provide the plan's schedule of benefits, identify the plan's deviations from the MCC standards, and provide additional information supporting his/her application. The Connector will review the materials provided by the applicant and will grant an MCC Certification if, in its discretion, it determines that the overall value of the benefits provided by the plan, despite the deviations identified by the applicant, provides sufficiently comprehensive coverage.

MCC Standards

In order to be eligible to apply for MCC Certification by the Connector, the health benefit plan must comply with the provisions of 956 CMR 5.03(3)(g); this means that a plan must:

- Provide coverage for all core services[1] (i.e., physician services, inpatient acute care services, day surgery, and diagnostic procedures and tests) defined in the Regulation; and

- Provide some level of coverage for each of the broad range of medical benefits listed in 956 CMR 5.03(2)(a) for the applicable calendar year commencing January 1, 2009, or on or after January 1, 2010.

  Effective January 1, 2009, "a broad range of medical benefits" shall include, at a minimum, coverage for:

  a. Preventive and Primary care
  b. Emergency services
  c. Hospitalization
  d. Ambulatory patient services
  e. Prescription drugs
  f. Mental health and substance abuse services

  Effective January 1, 2010, "a broad range of medical benefits" shall include, at a minimum, coverage for:

  a. Ambulatory patient services, including outpatient, day surgery and related anesthesia
  b. Diagnostic imaging and screening procedures, including x-rays
  c. Emergency services
  d. Hospitalization (including at a minimum, inpatient acute care services which are generally provided by an acute care hospital for covered benefits in accordance with the member's subscriber certificate or plan description)
  e. Maternity and newborn care
  f. Medical/surgical care, including preventive and primary care

[1] The Regulation prohibits an overall annual limit on core services collectively or individually by category. A health benefit plan may place limitations, however, on certain services within each category of core services. Nothing in the Regulation should be construed to restrict a plan sponsor's or carrier's ability to apply utilization management tools, such as pre-approval, prior authorization, closed prescription drug formularies, etc.

g. Mental health and substance abuse services
h. Prescription drugs
i. Radiation therapy and chemotherapy

- Have an actuarial value equal to or greater than any Bronze-level plan offered through the Connector.

For the period beginning January 1, 2010, a health benefit plan will not be granted an MCC Certification if:

- benefit limitations established by the health benefit plan are clearly inconsistent with standard employer-sponsored coverage; and

- benefit limitations established by the health benefit plan (that are inconsistent with standard employer-sponsored coverage) do not represent innovative ways to improve quality or manage the utilization or cost of services delivered.

Deviations from MCC standards.

A health benefit plan that deviates from the specified elements of the Regulation but meets the criteria above may apply to the Connector for MCC Certification. Some examples of deviations for which a plan may seek MCC Certification are:

- Coverage of preventive care services which deviates from the pre-deductible or nationally recognized standard requirements stipulated in the Regulation;

- Deductible amount(s) which exceed the limits set forth by Regulation or which are applied in a different manner than contemplated in Regulation;

- Out-of-Pocket (OOP) maximum amount which exceeds the limits set forth by Regulation or which are applied in a different manner than contemplated in Regulation.

The above examples are purely illustrative and do not constitute an exhaustive list of deviations for which a health benefit plan may seek MCC Certification.

When must a health benefit plan provide an actuarial attestation?

MCC Certification requires the overall value of a plan seeking MCC Certification to be equal to or greater than any Bronze-level plan offered through the Connector. Applicants will be required to state whether they believe that the health benefit plan in question meets this standard, and may eventually be required to submit an actuarial attestation to that effect. However, an applicant is not required to provide an actuarial attestation with the initial application.

The Connector has the sole discretion to request an actuarial attestation from an applicant in order to determine whether the health benefit plan meets the Connector's MCC standards. If the Connector cannot readily determine from a review of the initial application that the health benefit plan meets the actuarial standard, then the Connector is likely to request an actuarial attestation.

What is actuarial equivalence?

The actuarial value, typically expressed as a percent or fraction, is calculated based on the expected medical claims cost to the health plan to provide that health plan's benefits to a standard population. The value would take into account member cost-sharing. The actuarial value would also take into account any expected reduction in utilization caused by the presence of cost sharing that might cause a member not to pursue care for certain conditions.

Two plans are considered to be actuarially equivalent if they have the same or closely similar actuarial value. Therefore, the Connector will consider a plan to be actuarially equivalent to a Bronze-level plan if the applicant's plan has an actuarial value of at least 100% of any Connector Bronze-level plan. (Because of higher cost-sharing, the Connector's Bronze-level plans have actuarial values of approximately 60 percent of the value of the Connector's Gold-level plans.) The summary of benefits and cost-sharing for Bronze- and Gold-level plans can be found at www.mahealthconnector.org.

Aggregating Multiple Plans.

Under 956 CMR 5.03(2) and 5.03(2)(i), an individual may combine multiple plans in order to meet MCC. The Regulation provides the following examples:

- A health benefit plan that excludes prescription drug coverage may be combined with a separate prescription drug only health benefit plan so that, together in the aggregate, the combined health benefit plans satisfy 956 CMR 5.03(2)(c)3.

- A health benefit plan that excludes coverage for mental health services may be combined with a separate mental health carve-out so that, together in the aggregate, the combined health benefit plans satisfy the standards of minimum creditable coverage.

As an employer or plan sponsor, if the health coverage provided is made up of multiple health benefit plans you should combine the features and determine the aggregate value of the plans in assessing whether, as a whole, the health coverage meets MCC standards. If the plan you are submitting for MCC Certification is composed of several plans (e.g. certain benefits are carved out) you must provide information for all plans that make up your health coverage. Any actuarial attestation submitted must attest to the value of the combined health plans, but need not assess the value of each separate benefit (e.g., medical, mental health/substance abuse, prescription drugs).

Effective Date of an MCC Certification.

A health benefit plan's MCC Certification from the Connector is valid until there is a material change to the benefits provided by the plan and/or the Connector Board approves revisions to the Regulation that alters MCC standards. A material change is defined as a modification to a plan's benefit design (e.g., a change in covered benefits and/or cost sharing) that relates directly to MCC standards. Material changes to the plan of benefits and/or cost sharing that do not impact

MCC standards (e.g., the elimination of chiropractic coverage, changes to cost sharing for durable medical equipment, an increase in co-insurance for out-of-network coverage, etc.) would not require a plan sponsor or carrier to request MCC re-certification. If a plan does have a material change, a plan sponsor or carrier should re-apply for MCC Certification. An MCC Certification may be valid for:

- calendar year 2009 only, if the Connector determines that the plan meets MCC standards for calendar year 2009 but does not meet MCC standards for calendar year 2010; or

- calendar years 2009, 2010, and beyond, if the Connector determines that the plan meets MCC standards for calendar year 2010.

The Connector will work with the applicant if there are any questions with respect to the effective date or duration of the plan's MCC Certification.

The Connector reserves the right to withdraw a plan's MCC Certification if the Connector subsequently determines that any of the underlying facts, information, or circumstances are materially inconsistent with the representations and documents submitted in support of the MCC Certification Application.

Mental Health and Substance Abuse Services.

For purposes of the Regulation, mental health and substance abuse services are not considered core services. Mental health and substance abuse services are considered part of the broad range of medical services required to be covered, but a health benefit plan may place limitations as permitted by the Regulation.

In order to meet MCC standards, health benefit plan limitations on mental health and substance abuse services, must be consistent with applicable state and federal mental health parity requirements. The MCC Regulation neither exempts nor interferes with a plan's obligation to comply with state and federal laws to which it is subject.

Out-of-Pocket (OOP) Maximum.

If the health benefit plan's OOP maximum is calculated without including the deductible, a health benefit plan will satisfy the provisions of 956 CMR 5.03(2)(d) if the plan's OOP maximum for in-network covered services, when combined with the plan's deductible for in-network covered services, does not exceed $5,000 for an individual and $10,000 for a family.

If a health benefit plan includes co-insurance on core services[2] or an overall deductible but does not include an explicit OOP maximum for in-network covered services, it may still satisfy the provisions of 956 CMR 5.03(2)(d), if the member's OOP exposure would not exceed $5,000 for an individual and $10,000 for a family.

[2] Core services consist of physician services, inpatient acute care services, day surgery, and diagnostic procedures and tests.

High Deductible Health Plans (HDHPs).

2009. An HDHP will meet MCC in calendar year 2009 if it complies with federal statutory and regulatory requirements for HDHPs under 26 U.S.C. § 223 (i.e., Health Savings Account-compatible). The regulation does not require an individual to establish or fund a Health Savings Account (HSA).

2010. For the period beginning January 1, 2010, in order to meet MCC, an HDHP must be compliant with 26 U.S.C. § 223, must cover core services, must cover a broad range of medical benefits, and must facilitate access to an HSA. For purposes of MCC, "facilitate access to an HSA" means the plan sponsor and/or carrier must provide information to the policyholder explaining an HSA and how an individual may establish and fund an HSA if he/she so chooses. The Regulation does not require an individual to establish or fund an HSA.

Generally, an HDHP that is consistent with federal requirements under 26 U.S.C § 223 may only deviate from the requirements of MCC with regard to its deductibles and its OOP maximums. An HDHP otherwise must meet the requirements of the Regulation to the extent that such requirements are not inconsistent with federal statutory and regulatory requirements under 26 U.S.C § 223.

Collectively Bargained Plans.

A group health plan that is maintained pursuant to a collective bargaining agreement in effect on January 1, 2009, or that is part of a Multi-employer Health Benefit Plan that cannot self-assess as being MCC compliant may apply to the Connector for MCC Certification. Section 956 CMR 5.03(4) of the Regulation does not constitute an automatic safe harbor. In accordance with section 956 CMR 5.03(4), the Connector, in its discretion, after reviewing the totality of the circumstances of a particular request for MCC Certification, may grant MCC Certification for up to one year following the expiration of a collectively bargained agreement that is in effect on January 1, 2009 or, if part of a Multi-employer Health Benefit Plan, up to one year following the date of the last renewing collectively bargained agreement that is part of the Multi-employer Health Benefit Plan. This "grace period" is intended to allow the parties subject to a collective bargaining agreement time to modify their group health plans to meet MCC standards and then re-apply for MCC Certification to the MCC standards in effect at that time.

MCC CERTIFICATION APPLICATION

SECTION A

FOR APPLICANTS: This application is for employers, plan sponsors, carriers, third party administrators, consultants, and brokers who are looking to have the Connector determine if certain health benefit plans meet MCC standards. The Connector expects that employers, plan sponsors, carriers, third party administrators, consultants, and brokers will self-assess and determine whether their plans meet the MCC standards set forth in the MCC Regulation, 956 CMR 5.00. If you determine that your plan meets MCC standards set forth in the Regulation, you do not need to seek any form of approval or certification from the Connector. The majority of health benefit plans will fall into this self-assessment category. This application is designed to provide plans an alternative way to comply with MCC standards in instances in which a plan does not meet every element of the Regulation but is able to demonstrate that the plan's overall value is at least equal to a Connector's Bronze-level plan and that the plan provides sufficiently robust and comprehensive coverage so as to be deemed compliant with MCC, in the Connector's discretion.

FOR INDIVIDUALS: **Do not fill out this form if you are an individual taxpayer**.

I. Applicant's Contact Information: (Print Clearly)

First Name _____ Middle Name _____ Last Name _____

Street Address _____ City _____ State _____ Zip _____

Email Address _____ Telephone Number _____

Affiliation Name _____

II. Is the health benefit plan for which you are requesting MCC Certification subject to a Collective Bargaining Agreement?

□ Yes □ No

SECTION B
Health Benefit Plan Information

1. What is the name of your health benefit plan(s)?

_____

_____

2. Are you requesting a review for calendar year 2009, 2009 and beyond, or 2010 and beyond?

□ 2009 □ 2009 and beyond □ 2010 and beyond

3. You must include the plan's schedule of benefits. Have you included the plan's schedule of benefits?

□ Yes □ No

4. In order to be considered for MCC Certification, your plan must provide some level of coverage for all core services (i.e., physician services, inpatient acute care services, day surgery, and diagnostic procedures and tests).

5. In order to be considered for MCC Certification, your plan must provide some level of coverage for each of the broad range of medical benefits listed in 956 CMR 5.03(2)(a) for the applicable calendar year commencing January 1, 2009, or on or after January 1, 2010.

Effective January 1, 2009, "a broad range of medical benefits" shall include, at a minimum, coverage for:

a. Preventive and Primary care
b. Emergency services
c. Hospitalization
d. Ambulatory patient services
e. Prescription drugs
f. Mental health and substance abuse services

Effective January 1, 2010, "a broad range of medical benefits" shall include, at a minimum, coverage for:

a. Ambulatory patient services, including outpatient, day surgery and related anesthesia
b. Diagnostic imaging and screening procedures, including x-rays
c. Emergency services
d. Hospitalization (including at a minimum, inpatient acute care services which are generally provided by an acute care hospital for covered benefits in accordance with the member's subscriber certificate or plan description)
e. Maternity and newborn care
f. Medical/surgical care, including preventive and primary care
g. Mental health and substance abuse services
h. Prescription drugs
i. Radiation therapy and chemotherapy

6. Are you providing an actuarial attestation/certification that your health benefit plan meets or exceeds a Bronze-level plan offered through the Connector?

□ Yes □ No

You are not required to provide an actuarial attestation unless asked by the Connector. If you have any questions concerning an actuarial attestation, please see the Connector's Administrative Bulletin 01-08, Guidance Regarding MCC Certification.

7. If you are providing an actuarial attestation/certification, please provide the contact information for the individual who is attesting or certifying that the actuarial value of your plan meets or exceeds a Connector Bronze-level plan.

_____

Full Name Name of Firm (if Applicable)

_____

Email Address Telephone Number

SECTION B
Health Benefit Plan Information

8. Please identify the plan's deviation from the MCC requirements listed in 956 CMR 5.03(2).
You may attach a separate document(s).

9. Please provide any additional information supporting your Application for MCC Certification.
You may attach a separate document(s).

MCC.Certification@state.ma.us
Commonwealth Connector-MCC Review Unit
PO Box 960484, Boston, MA 02196
Telephone 1-617-933-3030 Fax. 1-617-933-3070
Business Hours: Monday through Friday 8am to 5pm

MCC CERTIFICATION APPLICATION

SECTION C
Applicant's Attestation

SIGN HERE

Under penalties of perjury, I declare that to the best of my knowledge and belief this Application and enclosures are true, correct and complete. I attest that I am authorized to submit this Application and the information contained herein or attached to this Application as/on behalf of the Applicant listed in Section A of this Application for the purpose of this MCC Certification request. I understand that if the Connector determines that any claims made in this MCC Certification Application are false, the Connector may revoke any MCC Certification the Applicant may receive with regard to this Application.

Your Signature Date

Print Name (First, Last)

Please send your application materials to:

MCC.Certification@state.ma.us
or
Commonwealth Connector-MCC Review Unit
PO Box 960484, Boston, MA 02196
or
Fax. 1-617-933-3070

2008-02 Requirements for Disclosure of Minimum Creditable Coverage

TO: **Commercial Health Insurers, Blue Cross and Blue Shield of Massachusetts, Inc., and Health Maintenance Organizations Offering or Renewing Insured Health Products in Massachusetts**

FROM: **Nonnie S. Burnes, Commissioner of Insurance**

DATE: **January 15, 2008**

RE: **Requirements for Disclosure of Minimum Creditable Coverage**

As of January 1, 2009, the Massachusetts Health Care Reform Law requires each Massachusetts resident, eighteen (18) years of age and older, to have health coverage that meets the Minimum Creditable Coverage ("MCC") standards set by the Commonwealth Health Insurance Connector ("Connector"), unless those plans meeting these standards are deemed to not be affordable to that person.

In order to help individuals determine if the health coverage they have or intend to purchase is sufficient to satisfy the individual mandate, this bulletin notifies all commercial health insurers, Blue Cross and Blue Shield of Massachusetts, Inc., and Health Maintenance Organizations (collectively "carriers") that offer or renew an individual or group insured health plan in Massachusetts, as defined in M.G.L. c. 176N, with coverage effective on or after February 1, 2008, that they are to disclose to insureds and potential insureds a plan's MCC status and whether the plan satisfies the individual coverage mandate of the Massachusetts Health Care Reform Law. Such disclosure shall be placed in a prominent location and in easily understandable language on the face or first page of text of the policy, certificate, or schedule of benefits that describes the specific plan benefits. The insured health plan's MCC status will be based on compliance with applicable standards in effect on and after January 1, 2009 as set forth by the Connector either by regulation or administrative bulletin

In the case of an employer-sponsored group insured health plan, said disclosure requirement also applies to marketing materials that describe the insured health plan benefits that are used during the employer's open enrollment period.

The required disclosure shall be placed on the face or first page of the text of the policy, certificate, or schedule of benefits that describes the specific plan benefits in substantially the same language and format as the following:

If the insured health plan **meets MCC** standards:

This health plan **meets Minimum Creditable Coverage standards** and **will satisfy** the individual mandate that you have health insurance. Please see page # for additional information.

If the plan **does not meet MCC** standards:

This health plan, alone, **does not meet Minimum Creditable Coverage standards** and **will not satisfy** the individual mandate that you have health insurance. Please see page # for additional information.

In addition, the following disclosure shall be placed within the body of the policy, certificate, or schedule of benefits in substantially the same language and format:

MASSACHUSETTS REQUIREMENT TO PURCHASE HEALTH INSURANCE:

As of January 1, 2009, the Massachusetts Health Care Reform Law requires that Massachusetts residents, eighteen (18) years of age and older, must have health coverage that meets the Minimum Creditable Coverage standards set by the Commonwealth Health Insurance Connector, unless waived from the health insurance requirement based on affordability or individual hardship. For more information call the Connector at 1-877-MA-ENROLL or visit the Connector website (www.mahealthconnector.org).

In addition, if the insured health plan **meets MCC** standards, use substantially the following language:

This health plan **meets Minimum Creditable Coverage standards** that are effective January 1, 2009 *(carriers are to substitute applicable date)* as part of the Massachusetts Health Care Reform Law. If you purchase this plan, you **will satisfy** the statutory requirement that you have health insurance meeting these standards.

On the other hand, if the plan **does not meet MCC** standards, use substantially the following language either as a check list or as an inserted statement that identifies the requirement(s) not met by the health plan:

This health plan, alone, **does not meet Minimum Creditable Coverage standards** that are effective January 1, 2009 *(carriers are to substitute applicable date)* as part of the Massachusetts Health Care Reform Law because *(carriers are to substitute applicable minimum creditable coverage standards as set by the Connector)*:

- The in-network deductible is more than $2,000 for an individual and/or $4,000 for a family.
- A broad range of medical benefits, as defined by the Connector, are not covered.
- Prescription drugs are not covered.
- The deductible for prescription drug coverage is more than $250 for an individual and/or $500 for a family.
- The health plan includes deductibles or coinsurance for in-network core services, but does not include an out-of-pocket maximum.
- The health plan includes deductibles or coinsurance for in-network core services, but the out-of-pocket maximum is more than $5,000 for an individual and/or $10,000 for a family.
- The health plan includes deductibles or coinsurance for in-network core services, but the out-of-pocket maximum does not include one or more of the following for in-network services: copayments over $100, coinsurance, or deductibles.
- The health plan imposes an overall annual maximum benefit or a per illness annual maximum benefit for covered core services.
- A fee schedule is imposed on indemnity benefits for in-network covered services.
- The deductible for in-network benefits does not exclude the required minimum of three preventive care visits for individual coverage and six preventive care visits for all other coverage types (i.e., two-person, individual plus child, family).

If you purchase this health plan only, **you will not satisfy** the statutory requirement that you have health insurance meeting these standards.

If this health plan is offered to you through your place of employment, contact your employer or other plan sponsor to determine if it offers other health plan options that meet Minimum Creditable Coverage standards. Your employer or other plan sponsor also may offer supplemental plans you can add to this insured health plan in order to meet Minimum Creditable Coverage.

If this health plan is not offered to you through your place of employment and you want to learn about other health plan options available to individuals, you may contact the Division of Insurance by calling (617) 521-7794 or visiting its website at www.mass.gov/doi, or the Connector by calling 1-877-MA-ENROLL or visiting its website at www.mahealthconnector.org.

The required disclosure also must include the following in substantially the same language and format:

THIS DISCLOSURE IS FOR MINIMUM CREDITABLE COVERAGE STANDARDS THAT ARE EFFECTIVE JANUARY 1, 2009 *(carriers are to substitute applicable date).* BECAUSE THESE STANDARDS MAY CHANGE, REVIEW YOUR HEALTH PLAN MATERIAL EACH YEAR TO DETERMINE WHETHER YOUR PLAN MEETS THE LATEST STANDARDS.

If you have questions about this notice, you may contact the Division of Insurance by calling (617) 521-7794 or visiting its website at www.mass.gov/doi.

If an insured accident and sickness plan is not considered a "health plan", as defined in M.G.L. c. 176N, the following disclosure notice must be included on the face or the first page of the text of the policy or certificate or on any required notice submitted with the product in substantially the same language and format:

This health plan, alone, **does not meet Minimum Creditable Coverage standards** and **will not satisfy** the individual mandate that you have health insurance. Please see page # for additional information.

In addition, the following disclosure shall be placed within the body of the policy, certificate, or any required notice submitted with the product in substantially the same language and format:

As of January 1, 2009, the Massachusetts Health Care Reform Law requires that Massachusetts residents, eighteen (18) years of age and older, must have health coverage that meets the Minimum Creditable Coverage standards set by the Commonwealth Health Insurance Connector, unless waived from the health insurance requirement based on affordability or individual hardship. For more information call the Connector at 1-877-MA-ENROLL or visit the Connector website (www.mahealthconnector.org) .

This plan is not intended to provide comprehensive health care coverage and **does not meetMinimum Creditable Coverage standards**, even if it does include services that are not available in the insured's other health plans.

If you have questions about this notice, you may contact the Division of Insurance by calling (617) 521-7794 or visiting its website at www.mass.gov/doi.

If there are any questions regarding this bulletin, please contact the Division of Insurance at (617) 521-7794.

TIR 09-1: Individual Mandate Penalties for Tax Year 2009

Pursuant to G.L. c. 111M, § 2, the Department of Revenue is issuing this Technical Information Release to announce the penalty schedule for individuals who fail to comply in 2009 with the requirements under the Massachusetts Health Care Reform Act (the Act). *See* St.2006, c. 58, as amended. The Act requires most adults 18 and over with access to affordable health insurance to obtain it. In 2009, individuals must be enrolled in health insurance policies that meet minimum creditable coverage standards defined in regulations adopted by the Commonwealth Health Insurance Connector Authority (the Connector). Individuals who are deemed able to afford health insurance but fail to comply are subject to penalties for each month of non-compliance in the tax year (provided that there is no penalty in the case of a lapse in coverage of 63 consecutive days or less). The penalties, which will be imposed through the individual's personal income tax return, shall not exceed 50% of the minimum monthly insurance premium for which an individual would have qualified through the Connector.[1]

These penalties apply *only* to adults who are deemed able to afford health insurance. On an annual basis, the Connector establishes separate standards that determine whether individuals, married couples and families can afford health insurance, based on their incomes and affordable health insurance premiums. Those who are not deemed able to afford health insurance pursuant to these standards will not be penalized. Individuals also have the opportunity to file appeals with the Connector asserting that hardship prevented them from purchasing health insurance (and thus that they should not be subject to tax penalties).[2]

For 2009:

- Individuals with incomes up to 150% of the Federal Poverty Level are not subject to any penalty for non-compliance, as those at this income level are not required to pay an enrollee premium for Commonwealth Care health insurance.
- Penalties for individuals with incomes from 150.1 to 300% of the Federal Poverty Level will be half of the lowest priced Commonwealth Care enrollee premium that could be charged to an individual at the corresponding income level, based on the Connector's Commonwealth Care enrollee premiums as of January 1, 2008.
- Penalties for individuals with incomes greater than 300% of the Federal Poverty Level will be:
  - *ages 18-26:* half of the lowest priced Commonwealth Choice Young Adult Plan premium; and
  - *ages 27 and above:* half of the lowest priced Commonwealth Choice Bronze premium, based on the Connector's prices for these plans as of January 1, 2009.
- The Department anticipates issuing an updated penalty schedule for tax year 2010.
- Penalties for married couples who do not comply with the individual mandate rules (with or without children) will equal the sum of individual penalties for each spouse.

Penalties for 2009

Individual Income Category*	150.1-200% FPL	200.1-250% FPL	250.1-300% FPL	Above 300% FPL Age 18-26	Above 300% FPL Age 27+
Penalty	$17/month $204/year	$35/month $420/year	$52/month $624/year	$52/month $624/year	$89/month $1,068/year

* Compare individual's annual family household income to chart immediately below to determine applicable Federal Poverty Level (FPL).
** Yearly penalty amounts listed above based on non-compliance for entire year.

Federal Poverty Level – Annual Income Standards

Family Size	150% FPL	200% FPL	250% FPL	300% FPL
1	$16,260	$21,672	$27,096	$32,508
2	$21,876	$29,160	$36,456	$43,740
3	$27,468	$36,624	$45,780	$54,936
4	$33,084	$44,112	$55,140	$66,168
5	$38,700	$51,600	$64,500	$77,400
6	$44,304	$59,064	$73,836	$88,596
7	$49,920	$66,552	$83,196	$99,828
8	$55,536	$74,040	$92,556	$111,060
For each additional person add	+$5,616	+$7,488	+$9,360	+11,232

This Schedule reflects the Federal Poverty Level standards for 2009.

/s/Navjeet K. Bal
Navjeet K. Bal
Commissioner of Revenue

NKB:MTF:adh

February 26, 2009

TIR 09-1

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[1] Thus, the monthly penalties apply to each month in which an individual lacks minimum creditable coverage (i.e., lacks health insurance coverage altogether, or lacks health insurance coverage meeting minimum creditable coverage standards). For more information regarding the health care individual mandate and minimum creditable coverage, including exceptions from the mandate and appeal rights of taxpayers in connection with the penalty under G.L. c. 111M, § 2, see Department of Revenue regulation 830 CMR 111M.2.1: Health Insurance Individual Mandate; Personal Income Tax Return Requirements, and Connector regulations 956 CMR 6.00, Determining Affordability for the Individual Mandate and 956 CMR 5.00, Minimum Creditable Coverage.

[2] See Connector regulation, 956 CMR 6.00, Determining Affordability for the Individual Mandate. The Affordability and Premium Schedules contained in the Massachusetts personal income tax forms are adopted by the Board of the Connector pursuant to 956 CMR 6.05.

Form MA 1099-HC
Individual Mandate
Massachusetts Health Care Coverage

2008

Massachusetts Department of Revenue

1 Name of insurance company or administrator

2 FID number of insurance co. or administrator

3 Name of subscriber

4 Date of birth

5 Subscriber number

6 Street address

7 City/Town

8 State

9 Zip

Full-year coverage? ☐ Yes ☐ No

If No, check months covered: ☐ Jan. ☐ Feb. ☐ Mar. ☐ Apr. ☐ May ☐ June ☐ July ☐ Aug. ☐ Sept. ☐ Oct. ☐ Nov. ☐ Dec.

Corrected:

a. Name of dependent

Date of birth

Subscriber number

Full-year coverage? ☐ Yes ☐ No

If No, check months covered: ☐ Jan. ☐ Feb. ☐ Mar. ☐ Apr. ☐ May ☐ June ☐ July ☐ Aug. ☐ Sept. ☐ Oct. ☐ Nov. ☐ Dec.

Corrected:

b. Name of dependent

Date of birth

Subscriber number

Full-year coverage? ☐ Yes ☐ No

If No, check months covered: ☐ Jan. ☐ Feb. ☐ Mar. ☐ Apr. ☐ May ☐ June ☐ July ☐ Aug. ☐ Sept. ☐ Oct. ☐ Nov. ☐ Dec.

Corrected:

c. Name of dependent

Date of birth

Subscriber number

Full-year coverage? ☐ Yes ☐ No

If No, check months covered: ☐ Jan. ☐ Feb. ☐ Mar. ☐ Apr. ☐ May ☐ June ☐ July ☐ Aug. ☐ Sept. ☐ Oct. ☐ Nov. ☐ Dec.

Corrected:

d. Name of dependent

Date of birth

Subscriber number

Full-year coverage? ☐ Yes ☐ No

If No, check months covered: ☐ Jan. ☐ Feb. ☐ Mar. ☐ Apr. ☐ May ☐ June ☐ July ☐ Aug. ☐ Sept. ☐ Oct. ☐ Nov. ☐ Dec.

Corrected:

YOU MUST COMPLETE AND ENCLOSE SCHEDULE HC WITH YOUR RETURN.

FIRST NAME | M.I. | LAST NAME | SOCIAL SECURITY NUMBER

Schedule HC Health Care Information. You must enclose this schedule with Form 1 or Form 1-NR/PY. 2008

Most Massachusetts residents age 18 and over are required to have health insurance if it is affordable for them or be subject to a penalty. Schedule HC, Health Care Information, must be completed by all full-year residents and certain part-year residents (see instructions).

1 **a.** Date of birth ► M M D D Y Y Y Y **b.** Spouse's date of birth ► M M D D Y Y Y Y

c. Family size (see instructions) ► ☐☐

2 Federal adjusted gross income. If married filing separately, see instructions. (from U.S. Forms 1040, line 37; 1040A, line 21; or 1040EZ, line 4) . . . . . ► 2 X , , .00

3 Did you have health insurance **at any point** during 2008? ► 3 You: ◯ Yes ◯ No Spouse: ◯ Yes ◯ No

If you are filing a joint return and one spouse answers **Yes** but the other spouse answers **No** or each spouse has different coverage, see instructions.

If you answer **No**, go to line 6 on page 2. If you answer **Yes**, follow the instructions below.

If you were enrolled in **Medicare, Veterans Administration Program, Tri-Care** or "Other" government health coverage **at any point** during 2008, **go to line 5** on page 2. **Note:** See below if you were enrolled in **MassHealth** or **Commonwealth Care**.

If you were enrolled in **MassHealth** and/or **Commonwealth Care** and private insurance, fill in the oval(s). Also, complete Part A and/or Part B below and then go to line 4. If you **only** had MassHealth and/or Commonwealth Care fill in the oval(s) and go to line 4.

► You: ◯ **MassHealth** and/or **Commonwealth Care**
► Spouse: ◯ **MassHealth** and/or **Commonwealth Care**

If you were enrolled in **private health insurance**, complete Part A and/or Part B below, using Form MA 1099-HC (see instructions if you did not receive Form MA 1099-HC from your carrier) and go to line 4.

Note: If you (and/or your spouse if married filing a joint return) had more than two insurance companies, complete Schedule HC-CS, Health Care Continuation Sheet (see instructions) to report the additional insurance company information, and fill in oval: ► ◯

PART A. YOUR HEALTH INSURANCE

1. NAME OF INSURANCE COMPANY OR ADMINISTRATOR (from box 1 of Form MA 1099-HC)

FEDERAL IDENTIFICATION NUMBER OF INSURANCE CO. (from box 2 of Form MA 1099-HC) | SUBSCRIBER NUMBER (from Form MA 1099-HC)

2. NAME OF SECOND INSURANCE COMPANY OR ADMINISTRATOR IF NECESSARY (from box 1 of Form MA 1099-HC)

FEDERAL IDENTIFICATION NUMBER OF INSURANCE CO. (from box 2 of Form MA 1099-HC) | SUBSCRIBER NUMBER (from Form MA 1099-HC)

PART B. SPOUSE'S HEALTH INSURANCE (you must complete even if covered under same insurance plan)

1. NAME OF INSURANCE COMPANY OR ADMINISTRATOR FOR SPOUSE (from box 1 of Form MA 1099-HC)

FEDERAL IDENTIFICATION NUMBER OF INSURANCE CO. (from box 2 of Form MA 1099-HC) | SPOUSE'S SUBSCRIBER NUMBER (from Form MA 1099-HC)

2. NAME OF SECOND INSURANCE COMPANY OR ADMINISTRATOR IF NECESSARY FOR SPOUSE (from box 1 of Form MA 1099-HC)

FEDERAL IDENTIFICATION NUMBER OF INSURANCE CO. (from box 2 of Form MA 1099-HC) | SPOUSE'S SUBSCRIBER NUMBER (from Form MA 1099-HC)

4 Were you insured for **all** of 2008? ► 4 You: ◯ Yes ◯ No Spouse: ◯ Yes ◯ No

If you are filing a joint return and one spouse answers **Yes** but the other spouse answers **No**, see instructions. If you answer **No**, go to line 6. If you answer **Yes**, you are not subject to a penalty. Skip the remainder of this schedule and continue completing your tax return.

YOU MUST COMPLETE AND ENCLOSE SCHEDULE HC WITH YOUR RETURN.

FIRST NAME | M.I. | LAST NAME | SOCIAL SECURITY NUMBER

5 If you were enrolled in Medicare, Veterans Administration Program, Tri-Care or "Other" government health coverage at any point during 2008 fill in the oval below for the plan in which you were enrolled. Skip the remainder of this schedule and continue completing your tax return. See instructions for information regarding "Other" government health coverage.

5a. ▸ You: ◯ Medicare ◯ Veterans Administration Program ◯ Tri-Care ◯ Other (enter name of program below)
5b. ▸ Spouse: ◯ Medicare ◯ Veterans Administration Program ◯ Tri-Care ◯ Other (enter name of program below)

NAME OF INSURANCE CARRIER OR PROGRAM

NAME OF INSURANCE CARRIER OR PROGRAM FOR SPOUSE

UNINSURED FOR ALL OR PART OF 2008

6 Was your income in 2008 at or below 150% of the federal poverty level (see table in instructions)? ▸ **6** ◯ Yes ◯ No

If you answer **Yes**, a penalty does not apply to you in 2008. Skip the remainder of this schedule and continue completing your tax return. If you answer **No**, go to line 7.

7 Were you uninsured for **all** of 2008? ▸ **7** You: ◯ Yes ◯ No
Spouse: ◯ Yes ◯ No

If you are filing a joint return and one spouse answers **Yes** but the other spouse answers **No**, see instructions. If you answer **Yes**, go to line 9a. If you answer **No**, go to line 8.

8 Complete this section **only** if you, and/or your spouse if married filing jointly, were uninsured for part, but not all of 2008. Fill in the ovals below for the months you were covered, using Form MA 1099-HC. If you did not receive this form, fill in the ovals for the months you were covered at least **15 days or more**.

See instructions if, during 2008, you turned 18, you were a part-year resident or a taxpayer was deceased.

MONTHS COVERED BY HEALTH INSURANCE

	JAN	FEB	MARCH	APRIL	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC
YOU:	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
SPOUSE:	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

If you had four or more consecutive months without health insurance (four or more blank ovals in a row), go to line 9a. Otherwise, a penalty does not apply to you in 2008. Skip the remainder of this schedule and continue completing your tax return.

RELIGIOUS EXEMPTION AND CERTIFICATE OF EXEMPTION

9 **a. RELIGIOUS EXEMPTION.** Are you claiming an exemption from the requirement to purchase health insurance based on your sincerely held religious beliefs? ▸ **9a** You: ◯ Yes ◯ No
Spouse: ◯ Yes ◯ No

If you answer **Yes**, go to line 9b. If you answer **No**, go to line 10. If you are filing a joint return and one spouse answers **Yes** but the other spouse answers **No**, see instructions.

b. If you are claiming a religious exemption in line 9a, did you receive medical health care during the 2008 tax year? ▸ **9b** You: ◯ Yes ◯ No
Spouse: ◯ Yes ◯ No

If you answer **No** to line 9b, skip the remainder of this schedule and continue completing your tax return. If you answer **Yes** to line 9b, go to line 10. If you are filing a joint return and one spouse answers **Yes** but the other spouse answers **No**, see instructions.

10 **CERTIFICATE OF EXEMPTION.** Have you obtained a Certificate of Exemption issued by the Commonwealth Health Insurance Connector Authority for the entire 2008 tax year or for the period you were uninsured in 2008? ▸ **10** You: ◯ Yes ◯ No
Spouse: ◯ Yes ◯ No

If you answer **Yes**, enter the certificate number below, skip the remainder of this schedule and continue completing your tax return. If you answer **No** to line 10, go to line 11. If you are filing a joint return and one spouse answers **Yes** but the other spouse answers **No**, see instructions.

YOUR CERTIFICATE NUMBER | SPOUSE'S CERTIFICATE NUMBER

BE SURE TO ENCLOSE SCHEDULE HC WITH YOUR RETURN.

FIRST NAME | M.I. | LAST NAME | SOCIAL SECURITY NUMBER

AFFORDABILITY AS DETERMINED BY STATE GUIDELINES

NOTE: This section will require the use of worksheets and tables found in the instructions. You **must** complete the worksheet(s) to determine if health insurance was affordable to you during the 2008 tax year.

11 Did your employer offer affordable health insurance as determined by completing the Schedule HC Worksheet for Line 11 in the instructions? ► **11** You: ○ Yes ○ No Spouse: ○ Yes ○ No

If your employer did not offer health insurance, you were not eligible for health insurance offered by your employer, you were self-employed or you were unemployed, fill in the **No** oval.

If you answer **No**, go to line 12. If you answer **Yes**, go to the Health Care Penalty Worksheet in the instructions to calculate your penalty amount.

12 Were you eligible for government-subsidized health insurance as determined by completing the Schedule HC Worksheet for Line 12 in the instructions? ► **12** You: ○ Yes ○ No Spouse: ○ Yes ○ No

If you answer **No**, go to line 13. If you answer **Yes**, go to the Health Care Penalty Worksheet in the instructions to calculate your penalty amount.

13 Were you able to afford private health insurance as determined by completing the Schedule HC Worksheet for Line 13 in the instructions? ► **13** You: ○ Yes ○ No Spouse: ○ Yes ○ No

If you answer **No**, you are not subject to a penalty. Continue completing your tax return. If you answer **Yes**, go to the Health Care Penalty Worksheet in the instructions to calculate your penalty amount.

COMPLETE ONLY IF YOU ARE FILING AN APPEAL

You may have grounds to appeal if you were unable to obtain affordable insurance in 2008 due to a hardship or other circumstances. The grounds for appeal are explained in more detail in the instructions. **If you believe you have grounds for appealing the penalty, fill in the oval(s) below.** The appeal will be heard by the Commonwealth Health Insurance Connector Authority. By filling in the oval below, you are authorizing DOR to share information from your tax return, including this schedule, with the Connector Authority for purposes of deciding your appeal.

After you file your return, you will receive a follow-up letter from the Connector Authority asking you to state your grounds for appeal in writing, and submit supporting documentation. **Failure to respond to that form within the time specified will lead to dismissal of your appeal.** Once the Connector Authority receives your documentation, it will be reviewed. You may be required to attend a hearing on your case. You will be required to file your claims under the pains and penalties of perjury.

Note: If you are filing an appeal, do **not** enter a penalty amount on your tax return. Also, do not include any hardship documentation with your original return. You will be required to submit substantiating hardship documentation at a later date during the appeal process.

YOU: ○ I wish to appeal the penalty. I authorize DOR to share my tax return including this schedule with the Commonwealth Health Insurance Connector Authority for purposes of deciding my appeal.

SPOUSE: ○ I wish to appeal the penalty. I authorize DOR to share my tax return including this schedule with the Commonwealth Health Insurance Connector Authority for purposes of deciding my appeal.

Note: If you, and your spouse if married filing a joint return, do not fill in the oval(s), your appeal will not be processed, and the Health Care Penalty will be assessed.

BE SURE TO ENCLOSE SCHEDULE HC WITH YOUR RETURN.

2008 Massachusetts **Schedule HC** Health Care

Instructions and Worksheets

Schedule HC

Health Care Information

As a result of the health care reform law, most Massachusetts residents age 18 and over are required to have health insurance, if it is affordable for them.

More information about the health care reform law and how to purchase affordable health insurance is available at the Commonwealth Health Insurance Connector Authority's website at www.mahealthconnector.org.

Special Circumstances During 2008

Note: Schedule HC must be completed and filed even if you fall into a "Special Circumstances" category.

Turning 18. If you turned 18 during 2008, the health care mandate applies to you beginning on the first day of the first full month following your birthday. For example, if your birthday is June 15, the mandate applies on July 1.

Part-year residents. If you moved into Massachusetts during 2008, the health care mandate applies to you beginning on the first day of the first full month following the month you became a resident of Massachusetts. For example, if you moved into Massachusetts on May 14, the mandate applies on June 1.

If you moved out of Massachusetts during 2008, the health care mandate applies to you up until the last day of the last full month you were a resident. For example, if you moved out of Massachusetts on July 10, the mandate applies up to June 30.

Deceased taxpayer. If a taxpayer dies during 2008, the health care mandate applies to the deceased taxpayer up until the last day of the last full month the taxpayer was alive. For example, if a taxpayer dies on August 4, the mandate applies up to July 30.

Lines 1a and 1b. Date of Birth

Enter your date of birth and the date of birth for your spouse (if married filing jointly).

Line 1c. Family Size

Enter your family size, including yourself, your spouse (if living in the same household at any point during the year) and any dependents as claimed on Form 1, line 2b or Form 1-NR/PY, line 4b. If married filing separately and living in the same household at any point during the year, also be sure to include in line 1c any dependents claimed on your tax return and any dependents claimed by your spouse on your spouse's tax return.

Line 2. Federal Adjusted Gross Income

Enter your federal adjusted gross income (from U.S. Form 1040, line 37; Form 1040A, line 21; or Form 1040EZ, line 4). If married filing separately **and** living in the same household, each spouse must combine their income figures from their separate U.S. returns when completing this section. Also, same-sex spouses filing a Massachusetts joint return or married filing separately **and** living in the same household must combine their income figures from their separate U.S. returns when completing this section.

Line 3. Health Insurance

You are considered to have been enrolled in a health insurance plan if you had coverage under private health insurance, such as coverage provided by an employer or purchased on your own, or government-sponsored health insurance at any point during 2008.

Note: Receiving services through the Health Safety Net Trust Fund (previously known as the "Uncompensated Care Pool" or "Free Care Pool") is **not** considered health insurance.

- If you (and your spouse if married filing jointly) answer **No**, go to line 6 on page 2 of Schedule HC.
- If you (and your spouse if married filing jointly) answer **Yes**, follow the instructions below that apply to your situation.

Joint filers. If one spouse answers Yes and the other answers No, the spouse who answered No must go to line 6 on page 2 of Schedule HC; the spouse who answered Yes must follow the instructions below. If you and your spouse had different health insurance coverage (for example, one spouse was covered by Medicare and the other by private insurance), each should follow the instructions below that apply.

- If you (and/or your spouse if married filing jointly) were enrolled in **Medicare, Veterans Administration Program, Tri-Care** or "**Other government health coverage**" at any point during 2008, fill in the Yes oval(s) in line 3 and then go to line 5 on page 2 of Schedule HC.

Note: Medicare includes supplemental or replacement plans that you may have purchased on your own.

"Other government health coverage" includes comprehensive government-subsidized plans such as care provided at a correctional facility. "Other" does **not** include the Health Safety Net Trust Fund, formerly known as the "Uncompensated Care Pool" or the "Free Care Pool" or, for purposes of this question, MassHealth or Commonwealth Care.

- If you (and/or your spouse if married filing jointly) were enrolled only in **MassHealth** and/or **Commonwealth Care**, fill in the Yes oval(s) in line 3 and the oval(s) for the plan(s) you were enrolled in and go to line 4.
- If you (and/or your spouse if married filing jointly) were enrolled in **MassHealth** and/or **Commonwealth Care** and **private insurance** during 2008, such as insurance provided by your employer, fill in the Yes oval(s) in line 3 and the oval(s) for the plan(s) you were enrolled in and complete Part A, Your Health Insurance and/or Part B, Spouse's Health Insurance and then go to line 4.
- If you (and/or your spouse if married filing jointly) were enrolled in **MassHealth** and/or **Commonwealth Care** and **Medicare**, fill in the Yes oval(s) in line 3 and then go to line 5 on page 2 of Schedule HC.
- If you (and/or your spouse if married filing jointly) were enrolled in **private health insurance**, fill in the Yes oval(s) in line 3 and complete Part A (for you) and/or B (your spouse) using Form(s) MA 1099-HC. This form will be issued to you by your health insurance carrier or administrator, no later than January 31, 2009.

Note: Generally, employees or retirees of the federal, state or local governments have private health insurance and should fill in the Yes oval(s) in line 3 and complete Part A (for you) and/or Part B (your spouse) in line 3 and then go to line 4.

If you and your spouse were enrolled in the same health insurance, you must complete both Part A (for you) and Part B (your spouse) in line 3.

If you did not receive Form MA 1099-HC, enter the name of your insurance carrier or administrator and your subscriber number in Parts A and/or B. This information should be on your insurance card. If you do not know this information, contact your insurer.

Parts A and B allow you (and/or your spouse if married filing jointly) to provide information on up to two insurance carriers each, if you (and/or your spouse if married filing jointly) were covered by multiple insurers in 2008.

If you (and/or your spouse if married filing jointly) had health insurance from more than two insurance carriers, fill out **Schedule HC-CS, Health Care Continuation Sheet**. If you file Schedule HC-CS, report your two most recent insurance carriers first on Schedule HC and use Schedule HC-CS to report the additional insurance carriers for yourself (and/or your spouse if married filing jointly). Schedule HC-CS is available on DOR's website at www.mass.gov/dor.

Line 4. Full-Year Coverage

You are considered to have coverage for all of 2008 if you had coverage for each of the 12 months in 2008.

- If you are filing a joint return, and one spouse answers **Yes** in line 4 and the other answers **No**, the spouse who answered **Yes** is not subject to a penalty and should skip the remainder of Schedule HC. The spouse who answered **No** must go to line 6.

Table 1: Federal Poverty Level, Annual Income Standards

Family size*	150% FPL
1	$15,612
2	$21,012
3	$26,412
4	$31,812
5	$37,212
6	$42,612
7	$48,012
8	$53,412
additional	+$ 5,400

*This Schedule reflects the Federal Poverty Level standards for 2008

- If you (and your spouse if married filing jointly) answer **No**, go to line 6 on page 2 of Schedule HC.
- If you (and your spouse if married filing jointly) answer **Yes**, you are not subject to a penalty. Skip the remainder of Schedule HC and continue completing your tax return. Be sure to enclose Schedule HC with your return.

Line 5. Government-Sponsored Health Insurance

If you (and/or your spouse if married filing jointly) were enrolled in **Medicare, Veterans Administration Program, Tri-Care** or "**Other government health coverage**" at any point in 2008 (see below for definition of "Other"), fill in the appropriate oval(s) for the plan(s) you were enrolled in. You are not subject to a penalty. Skip the remainder of Schedule HC and continue completing your return. Be sure to enclose Schedule HC with your return.

Note: Fill in the Medicare oval(s) even if you have a supplemental or replacement plan that you may have purchased on your own.

"**Other government health coverage**" includes comprehensive government-subsidized plans such as care provided at a correctional facility. "**Other**" does **not** include the Health Safety Net Trust Fund, formerly known as the "Uncompensated Care Pool" or the "Free Care Pool" or, for purposes of this question, MassHealth or Commonwealth Care.

Line 6. Federal Poverty Level

Individuals with income at or below 150% of the Federal Poverty Level (FPL) are not subject to a penalty for failure to purchase health insurance. Complete the following worksheet to determine if your income is at or below 150% of the Federal Poverty Level.

1. Enter your federal adjusted gross income from Schedule HC, line 2 . . . . . _____
2. Enter the income amount that corresponds to your family size (as entered on Schedule HC, line 1c) from the 150% FPL column from Table 1 . . . . . _____

If line 1 is less than or equal to line 2, your income in 2008 was at or below 150% of the Federal Poverty Level and the penalty does not apply to you in 2008. Fill in the Yes oval in line 6, skip the remainder of Schedule HC and continue completing your tax return.

If line 1 is greater than line 2, your income in 2008 was above 150% of the Federal Poverty Level. Fill in the No oval in line 6 and go to line 7.

Line 7. Uninsured

You are considered uninsured for all of 2008 if you did not have **any** coverage under **private health insurance** (examples of which include employer-sponsored insurance, Commonwealth Choice plans or COBRA) or **government-sponsored health insurance** (examples of which include MassHealth or Commonwealth Care).

Note: If, during 2008, you turned 18, you were a part-year resident or a taxpayer was deceased, be sure to answer **No** to line 7 and go to line 8.

- If you are filing a joint return and one spouse had health insurance for all of 2008, the spouse who had health insurance does not fill in an oval on line 7. If you are filing a joint return and one spouse answers **No** but the other spouse answers **Yes** on line 7, the spouse who answers **No** must go to line 8 and the spouse who answers **Yes** must go to line 9a.
- If you (and/or your spouse if married filing jointly) answer **No**, go to line 8.
- If you (and/or your spouse if married filing jointly) answer **Yes**, go to line 9a.

Line 8. Months Covered by Health Insurance

Complete this section **only if** you (and/or your spouse if married filing jointly) were insured for part, **but not all**, of 2008. You are considered to have coverage for part of 2008 if you had coverage for at least 1 but less than 12 months.

If you were enrolled in a **private health insurance plan** (such as coverage provided by your employer or purchased on your own) or **government-sponsored health insurance** (examples of which include MassHealth or Commonwealth Care), fill in the oval(s) for the months you were covered, using the information from Form(s) MA 1099-HC.

If you did not receive a Form MA 1099-HC from your insurance carrier, fill in the oval(s) for each month in which you had coverage for **15 days or more**. If you had coverage in any month for 14 days or less, you must leave the oval(s) blank.

Note for MassHealth and Commonwealth Care enrollees: If you did not receive a Form MA 1099-HC and you answered No to line 6, please call MassHealth at 1-866-682-6745 or Commonwealth Care at 1-877-623-6765 for a copy. If you answered Yes to line 6, you do not need to complete this section and you do not need a Form MA 1099-HC.

- If you have **four or more** consecutive months without health insurance (**four or more** blank ovals in a row), go to line 9a. Otherwise, you are not subject to a penalty. Skip the remainder of Schedule HC and continue completing your return. Be sure to enclose Schedule HC with your return.
- If you are filing a joint return and one spouse has **three or fewer** blank ovals in a row, and the other spouse has **four or more** blank ovals in a row, the spouse with **three or fewer** blank ovals in a row is **not** subject to a penalty and should skip the remainder of Schedule HC. The spouse with **four or more** blank ovals in a row must go to line 9a.

Special Circumstances During 2008

Note: Schedule HC must be completed and filed even if you fall into a "Special Circumstances" category. Also, **do not count** the months that the mandate did not apply when determining if you have four or more consecutive months without health insurance.

Turning 18. If you turned 18 during 2008, the health care mandate applies to you beginning on the first day of the first full month following your birthday. For example, if your birthday is June 15, the mandate applies on July 1. In this example, do not count the months of January through June because the mandate did not apply.

Part-year residents. If you moved **into** Massachusetts during 2008, the health care mandate applies to you beginning on the first day of the first full month following the month you became **domiciled** in (a resident of) Massachusetts. For example, if you moved into Massachusetts on May 14, the mandate applies on June 1. In this example, do not count the months of January through May because the mandate did not apply.

If you moved **out of** Massachusetts during 2008, the health care mandate applies to you up until the last day of the last full month you were a resident. For example, if you moved **out of** Massachusetts on July 10, the mandate applies up to June 30. In this example, do not count the months of July through December because the mandate did not apply.

Deceased taxpayer. If a taxpayer died during 2008, the health care mandate applies to the deceased taxpayer up until the last day of the last full month the taxpayer was alive. For example, if a taxpayer

died on August 4, the mandate applies up to July 30. In this example, do not count the months of August through December because the mandate did not apply.

Line 9. Religious Exemption

Line 9a. A religious exemption is available for anyone who has a sincere religious belief that is the basis of refusal to obtain and maintain health insurance coverage. Fill in the Yes oval(s) if you are claiming a religious exemption from the requirement to purchase health insurance based on your sincerely held religious beliefs.

- If you (and your spouse if married filing jointly) answer **Yes** to line 9a, go to line 9b.
- If you (and your spouse if married filing jointly) answer **No** to line 9a, go to line 10.
- If you are filing a joint return and one spouse answers **No** to line 9a but the other spouse answers **Yes**, the spouse who answered **Yes** must go to line 9b and the spouse who answered **No** must go to line 10.

Line 9b. If you are claiming a religious exemption but you received medical health care during tax year 2008, such as treatment during an emergency room visit, you may be subject to a penalty if it is determined that you could have afforded health insurance.

Medical health care excludes certain treatments such as preventative dental care, certain eye examinations and vaccinations. It also excludes a physical examination when required by a third party, such as a prospective employer. For additional information, see Department of Revenue regulation 830 CMR 111M.2.1, Health Insurance Individual Mandate; Personal Income Tax Return Requirements, available on the department's website at www.mass.gov/dor.

- If you (and your spouse if married filing jointly) answer **Yes** on line 9a and **No** on line 9b, the penalty does not apply to you. Skip the remainder of Schedule HC and continue completing your tax return. Be sure to enclose Schedule HC with your return.
- If you (and your spouse if married filing jointly) answered **Yes** on both lines 9a and 9b, go to line 10.
- If you are filing a joint return and one spouse answers **No** to line 9b but the other spouse answers **Yes** to line 9b, the spouse who answered **No** is not subject to a penalty and should skip the remainder of Schedule HC. The spouse who answered **Yes** must go to line 10.

Line 10. Certificate of Exemption

The Commonwealth Health Insurance Connector Authority provided certificates of exemption to qualified taxpayers who applied in 2008.

- If you have a "**Certificate of Exemption**" issued by the Commonwealth Health Insurance Connector Authority for the 2008 tax year, a penalty does not apply to you. Fill in the **Yes** oval(s) in line 10 of Schedule HC and enter the certificate number in the space provided. If married filing jointly and both spouses have a certificate, each spouse must enter their certificate number in the space provided. Skip the remainder of Schedule HC and continue completing your tax return. Be sure to enclose Schedule HC with your return.
- If you answered **No** to line 10, go to line 11.
- If you are filing a joint return and one spouse answers **Yes** to line 10 but the other spouse answers **No** to line 10, the spouse who answered **Yes** must enter the certificate number and skip the remainder of Schedule HC and the spouse who answered **No** must go to line 11.

For more information about Certificates of Exemption, visit the Commonwealth Health Insurance Connector Authority's website at www.mahealthconnector.org.

Lines 11, 12 and 13. Affordability As Determined By State Guidelines

Taxpayers who did not have health insurance for all or part of 2008 may be subject to a penalty if they had access to affordable health insurance.

If you answered Yes in line 6 of Schedule HC indicating that your income was at or below 150% of the Federal Poverty Level, or

If you had three or fewer blank ovals in a row as shown in line 8,

you are not subject to a penalty and should skip the remainder of Schedule HC and continue completing your tax return. Be sure to enclose Schedule HC with your return.

You must complete this section if you were uninsured for all of 2008 or if you had four or more consecutive months without health insurance (four or more blank ovals in a row in the Months Covered by Health Insurance section of line 8).

The following pages contain the worksheets and tables needed to determine if you had access to affordable health insurance. To complete these worksheets, you will need to have your completed 2008 U.S. Form 1040, 1040A or 1040EZ. You also will need to know how much it would have cost you to enroll in any health insurance plan offered by an employer in 2008. An employer's Human Resources Department should be able to provide this amount to you.

Schedule HC Worksheet for Line 11: Eligibility for Employer-Sponsored Insurance

The following worksheet will determine if you could have afforded employer-sponsored health insurance in 2008. Complete only if you (and/or your spouse if married filing jointly) were eligible for insurance offered by an employer for the entire period you were uninsured in 2008 that covered you, and your spouse and dependent children, if any. If an employer did not offer health insurance that covered you, and your spouse and dependent children, if any, or if you were not eligible for insurance offered by an employer, you were self-employed or you were unemployed, fill in the No oval(s) in line 11 and complete the Schedule HC Worksheet for Line 12.

***Note:** If you answered Yes in line 6 of Schedule HC indicating that your income was at or below 150% of the Federal Poverty Level or you had three or fewer blank ovals in a row on line 8 of Schedule HC, the penalty does not apply to you. Do not complete this worksheet. Skip the remainder of Schedule HC and continue completing your return. Be sure to enclose Schedule HC with your return.*

If an employer offered you free health insurance coverage in 2008 (the employer's Human Resources Department should be able to provide this information to you), you are deemed able to afford health insurance and are subject to a penalty. Fill in the Yes oval(s) in line 11 and go to the Health Care Penalty Worksheet on page HC-8.

***1.** Enter your federal adjusted gross income from U.S. Form 1040, line 37; Form 1040A, line 21; or 1040EZ, line 4 . . . . . _____*

If line 1 is less than or equal to:

- *$15,612 if single or married filing separately with no dependents;*
- *$21,012 if married filing a joint return with no dependents; **or***
- *$26,412 if head of household, married filing jointly or married filing separately with one or more dependents,*

you are deemed unable to afford employer-sponsored health insurance requiring an employee contribution. Fill in the No oval(s) in line 11. Skip the remainder of this worksheet and go to the Schedule HC Worksheet for Line 12 on page HC-5.

If line 1 is more than:

- *$52,500 if single or married filing separately with no dependents;*
- *$82,500 if married filing a joint return with no dependents; **or***
- *$110,000 if head of household, married filing jointly or married filing separately with one or more dependents,*

you are deemed able to afford employer-sponsored health insurance and are subject to a penalty. Fill in the Yes oval(s) in line 11 and go to the Health Care Penalty Worksheet on page HC-8.

If line 1 is:

• more than $15,612 but less than or equal to $52,500 if single or married filing separately with no dependents;

• more than $21,012 but less than or equal to $82,500 if married filing a joint return with no dependents; ***or***

• more than $26,412 but less than or equal to $110,000 if head of household, married filing jointly or married filing separately with one or more dependents,

go to line 2.

2. *Enter the monthly premium that corresponds with your income range (from line 1 of worksheet) and filing status from Table 3: Affordability on page HC-7. To find this amount, look at the row for your income range in col. a of the appropriate table based on your filing status and go to col. b to find the monthly premium amount . . . . . _____*

3. *Enter the lowest monthly premium cost of health insurance that would cover you, and your spouse and dependent children, if any, offered to you during your uninsured period in 2008 through an employer. The employer's Human Resources Department should be able to provide this amount to you . . . . . _____*

Note: *If you declined employer-sponsored health insurance, the monthly premium amount may be found on the Health Insurance Responsibility Disclosure Form (HIRD) you should have received from your employer.*

If line 3 is less than or equal to line 2:

• you are deemed able to afford employer-sponsored health insurance during your uninsured period(s), which you did not obtain, and

• you are subject to a penalty. Fill in the Yes oval(s) in line 11, ***and***

• go to the Health Care Penalty Worksheet on page HC-8.

If line 3 is greater than line 2:

• you could not afford health insurance offered to you by your employer,

• fill in the No oval(s) in line 11, ***and***

• complete the following Schedule HC Worksheet for Line 12.

Schedule HC Worksheet for Line 12: Eligibility for Government-Subsidized Health Insurance

The following worksheet will determine if you were eligible for government-subsidized health insurance in 2008. Complete the following worksheet only if an employer did not offer you affordable health insurance, as determined in the Schedule HC Worksheet for Line 11.

Note: *If you answered Yes in line 6 of Schedule HC indicating that your income was at or below 150% of the Federal Poverty Level or you had three or fewer blank ovals in a row on line 8 of Schedule HC, the penalty does not apply to you. Do not complete this worksheet. Skip the remainder of Schedule HC and continue completing your return. Be sure to enclose Schedule HC with your return.*

If married filing separately ***and*** *living in the same household, each spouse must combine their income figures from their separate U.S. returns when completing this worksheet. Also, same-sex spouses filing a Massachusetts joint return or married filing separately* ***and*** *living in the same household must combine their income figures from their separate U.S. returns when completing this worksheet.*

1. *Enter your income before adjustments (from U.S. Form 1040, line 22, Form 1040A, line 15 or Form 1040EZ, line 4). . . . _____*

2. *Enter the amount from the Income column, based on your family size (do not include dependent children age 19 or older in your family size), from Table 2. . . . . _____*

If line 1 is greater than line 2:

you were ineligible for government-subsidized health insurance in 2008 and must

• fill in the No oval(s) in line 12, ***and***

• go to Schedule HC Worksheet for Line 13 to determine if you were deemed able to afford private health insurance.

If line 1 is less than or equal to line 2, and at any point during the period when you were uninsured:

• you were not a citizen or an alien legally residing in the U.S., ***or***

• an employer offered to pay more than 20% of a family plan or 33% of an individual plan (the employer's Human Resources Department should be able to provide this information to you), ***or***

• you applied for MassHealth or Commonwealth Care and were denied,

you are deemed ineligible for government-subsidized health insurance in 2008 and must

• fill in the No oval(s) in line 12, ***and***

• go to Schedule HC Worksheet for Line 13 to determine if you were able to afford private health insurance.

If line 1 is less than or equal to line 2, and none of the above conditions apply, then

• you would have been deemed eligible for government-subsidized health insurance in 2008, which you did not obtain and you are subject to a penalty. You must

• fill in the Yes oval(s) in line 12 and go to the Health Care Penalty Worksheet on page HC-8.

If line 1 is less than or equal to line 2, but you believe that, during the period when you were uninsured, your income was actually too high to qualify for government-subsidized insurance, you may have grounds to appeal the penalty. Fill in the Yes oval(s) in line 12 and go to the instructions for the Appeals section on page HC-9.

Table 2: Income at 300% of the Federal Poverty Level

Family size*	Income
1	$ 31,212
2	$ 42,012
3	$ 52,812
4	$ 63,612
5	$ 74,412
6	$ 85,212
7	$ 96,012
8	$106,812
9	$117,612
10	$128,412
11	$139,212
12	$150,012
13	$160,812

*Include only yourself, your spouse (if married filing a joint return) and any dependent children age 18 or younger in your family size. For family size over 13, add $10,800 for each additional family member.

Schedule HC Worksheet for Line 13: Ability to Afford Private Health Insurance

The following worksheet will determine if you could have afforded private health insurance in 2008. Complete the following worksheet only if you (and/or your spouse if married filing jointly) were deemed ineligible for government-subsidized health insurance, as determined in the Schedule HC Worksheet for line 12.

***Note:** If you answered Yes in line 6 of Schedule HC indicating that your income was at or below 150% of the Federal Poverty Level or you had three or fewer blank ovals in a row in line 8 of Schedule HC, the penalty does not apply to you. Do not complete this worksheet. Skip the remainder of Schedule HC and continue completing your return. Be sure to enclose Schedule HC with your return.*

***1.** Enter your federal adjusted gross income from U.S. Form 1040, line 37; Form 1040A, line 21; or 1040EZ, line 4 . . . . . _____*

***2.** Enter the monthly premium that corresponds with your county of residency (see page HC-10 in the Schedule HC instructions if you do not know what county you live in), age (if married filing a joint return, use the age of the older spouse) and filing status from Table 4: Premiums on page HC-7 . . . . . _____*

Go to the table that corresponds to your county of residency and go to the row for your age range and then go to the column based on your filing status to find the monthly premium amount.

***3.** Enter the monthly premium that corresponds with your income range (from line 1 of worksheet) and filing status from Table 3: Affordability on page HC-7. To find this amount, look at the row for your income range in col. a of the appropriate table based on your filing status and go to col. b to find the monthly premium amount . . . . . _____*

If line 2 is less than or equal to line 3:

- *you are deemed able to afford private health insurance, which you did not obtain;*
- *you are subject to a penalty and you must*
- *fill in the Yes oval(s) in line 13 and go to the Health Care Penalty Worksheet on page HC-8.*

If line 2 is greater than line 3:

- *you are deemed unable to afford health insurance and **not** subject to a penalty, and you must*
- *fill in the No oval(s) in line 13 **and***
- *skip the remainder of Schedule HC and continue completing your tax return. Be sure to enclose Schedule HC with your return.*

Table 3: Affordability

Individual or Married Filing Separately (no dependents)		
a. Federal adjusted gross income		b. Monthly premium
From	To	
$ 0	$15,612	$ 0
$15,613	$20,808	$ 39
$20,809	$26,016	$ 77
$26,017	$31,212	$116
$31,213	$37,500	$165
$37,501	$42,500	$220
$42,501	$52,500	$330
$52,501	Any individual with an annual income over $52,500 is deemed to be able to afford health insurance.	

Married Filing Jointly (no dependents)		
a. Federal adjusted gross income		b. Monthly premium
From	To	
$ 0	$21,012	$ 0
$21,013	$28,008	$ 78
$28,009	$35,016	$154
$35,017	$42,012	$232
$42,013	$52,500	$297
$52,501	$62,500	$396
$62,501	$82,500	$550
$82,501	Any couple with an annual income over $82,500 is deemed to be able to afford health insurance.	

Head of Household, Married Filing Jointly or Married Filing Separately (1 or more dependents)		
a. Federal adjusted gross income		b. Monthly premium
From	To	
$ 0	$ 26,412	$ 0
$26,413	$ 35,208	$ 78
$35,209	$ 44,016	$154
$44,017	$ 52,812	$232
$52,813	$ 70,000	$352
$70,001	$ 90,000	$550
$90,001	$110,000	$792
$110,001	Any family with an annual income over $110,000 is deemed to be able to afford health insurance.	

Table 4: Premiums

Region 1. Berkshire, Franklin and Hampshire Counties			
Age	Individual*	Married couple (no dependents)	Family**
0–26	$120	$240	$ 710
27–29	$210	$420	$ 710
30–34	$210	$420	$ 740
35–39	$220	$440	$ 770
40–44	$240	$480	$ 780
45–49	$275	$550	$ 820
50–54	$360	$720	$ 950
55–59	$400	$800	$1,060
60+	$400	$800	$1,140

Region 2. Bristol, Essex, Hampden, Middlesex, Norfolk, Suffolk and Worcester Counties			
Age	Individual*	Married couple (no dependents)	Family**
0–26	$140	$280	$ 600
27–29	$195	$390	$ 600
30–34	$195	$390	$ 740
35–39	$195	$390	$ 760
40–44	$250	$500	$ 760
45–49	$250	$500	$ 810
50–54	$290	$580	$ 890
55–59	$390	$780	$1,040
60+	$390	$780	$1,190

Region 3. Barnstable, Dukes, Nantucket and Plymouth Counties			
Age	Individual*	Married couple (no dependents)	Family**
0–26	$130	$260	$ 680
27–29	$210	$420	$ 680
30–34	$230	$460	$ 720
35–39	$270	$540	$ 750
40–44	$320	$640	$ 760
45–49	$370	$740	$ 800
50–54	$420	$840	$ 920
55–59	$420	$840	$1,120
60+	$420	$840	$1,280

***Includes married filing separately (no dependents).**
****Head of household or married couple with dependent(s).**

Health Care Penalty Worksheet

Complete the following worksheet to calculate the penalty. If married filing a joint return and both you and your spouse are subject to a penalty, separate worksheets must be filled out to calculate the separate penalty amounts for you and your spouse, using your married filing jointly income. Each separate penalty amount must then be entered on Form 1, line 34a and line 34b or Form 1-NR/PY, line 39a and line 39b.

***Note:** If you answered Yes in line 6 of Schedule HC indicating that your income was at or below 150% of the Federal Poverty Level, the penalty does not apply to you. Do not complete this worksheet. Skip the remainder of Schedule HC and continue completing your tax return.*

***1.** Enter your federal adjusted gross income from Schedule HC, line 2 . . . . . _____*
***2.** Look at Table 5, Annual Income Standards, and enter col. A, B, C or D, based on your family size (from line 1c of Schedule HC) and income (from line 1 above) . . . . . _____*
***3.** Based on the column entered in line 2, go to Table 6, Penalties for 2008, to determine the monthly penalty amount. Enter that amount here. If you entered col. D, enter the penalty amount that corresponds to your age . . . . . _____*

***Note:** See examples at right when completing lines 4 and 5.*

***4.** Enter the number of gap(s) in coverage of four or more consecutive months in which you were uninsured, as shown in Sched. HC, line 8*. If you were uninsured for all of 2008, enter "0" . . . . . _____*
***5.** Enter the total number of months for the gap(s) in coverage in which you were uninsured from line 4. If you were uninsured for all of 2008, enter "12" . . . . . _____*
***6.** Multiply line 4 by "3". . . . . _____*
***7.** Subtract line 6 from line 5. . . . . _____*
***8.** Multiply line 3 by line 7. This is your penalty amount . . . . . _____*

***Note:** See page 9 of the Form 1 instructions for information regarding the whole-dollar method.*

*If you are subject to a penalty because you are deemed able to afford insurance in 2008 but did not obtain it, you may appeal the application of the penalty to you. Go to the Filing an Appeal section on Schedule HC and in the instructions on page HC-9. If you are filing an appeal, do not enter a penalty amount on Form 1, line 34a or line 34b or Form 1-NR/PY, line 39a or line 39b. If you are **not** appealing the penalty, enter the penalty amount from line 8 on Form 1, line 34a or line 34b or Form 1-NR/PY, line 39a or line 34b.*

***Turning 18, Part-Year Residents or a Taxpayer Was Deceased.** When completing line 4, do not include the number of unfilled ovals for months that the mandate did not apply, as determined in Schedule HC, line 8.*

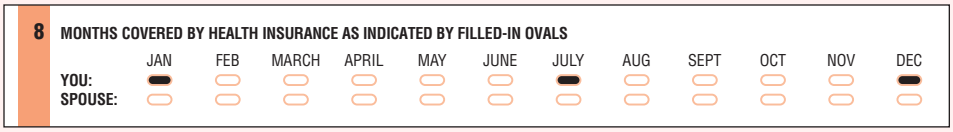
Table 5: Annual Income Standards

Family size	Col. A		Col. B		Col. C		Col. D
	From	To	From	To	From	To	Above
1	$15,613	$20,808	$20,809	$26,016	$26,017	$31,212	$31,212
2	21,013	28,008	28,009	35,016	35,017	42,012	42,012
3	26,413	35,208	35,209	44,016	44,017	52,812	52,812
4	31,813	42,408	42,409	53,016	53,017	63,612	63,612
5	37,213	49,608	49,609	62,016	62,017	74,412	74,412
6	42,613	56,808	56,809	71,016	71,017	85,212	85,212
7	48,013	64,008	64,009	80,016	80,017	96,012	96,012
8	53,413	71,208	71,209	89,016	89,017	106,812	106,812
Additional	+ $ 5,400	+ $ 7,200	+ $ 7,200	+ $ 9,000	+ $ 9,000	+ $10,800	+ $10,800

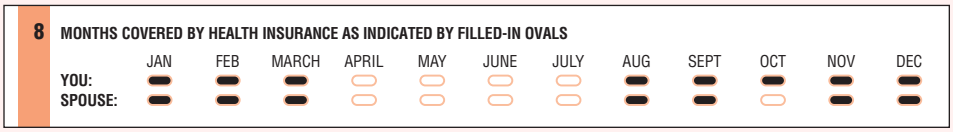
Table 6: Penalties for 2008

Col.	Monthly penalty amount
A	$17.50
B	$35.00
C	$52.50
D-1 (age 18–26)*	$56.00
D-2 (age 27+)*	$76.00

*If you turned 27 on or before December 31, 2008, use the Column D-1 (age 18-26) amount in line 3 of the Health Care Penalty Worksheet.

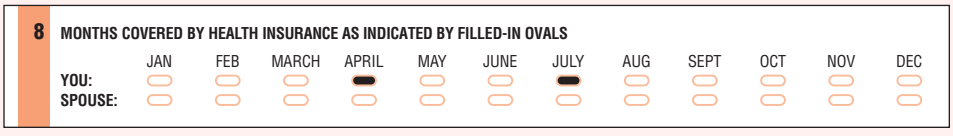


Example A for Health Care Penalty Worksheet, lines 4 and 5
Single taxpayer enters "2" on line 4 because there were two gaps in coverage of four or more consecutive months (Feb.–June and Aug.–Nov.). Taxpayer then enters "9" in line 5 because the total number of months for those gaps is 9 months.



Example B for Health Care Penalty Worksheet, lines 4 and 5
You are a married filing jointly couple completing separate worksheets. You enter "1" on line 4 because there is only one four-month gap in coverage (April–July). You then enter "4" in line 5 because the total number of months for that gap is 4 months.

Spouse also enters "1" on line 4 because only one of the gaps in coverage was four or more consecutive months (April–July). Spouse then enters "4" in line 5 because the total number of months for that gap is 4 months.



Example C for Health Care Penalty Worksheet, lines 4 and 5
Single taxpayer enters "1" on line 4 because only one of the gaps in coverage was four or more consecutive months (Aug.–Dec.). Taxpayer then enters "5" in line 5 as the total number of months within that gap period is 5 months.

Filing an Appeal

If you are subject to a penalty for not obtaining health insurance in 2008, you have the right to appeal. The appeal will be heard by the Commonwealth Health Insurance Connector Authority, an independent state body.

In your appeal, you may claim that the penalty should not apply to you. You may claim that you could not afford insurance in 2008 because you experienced a hardship. To establish a hardship, you must be able to show that, during 2008:

(a) You were homeless, more than 30 days in arrears in rent or mortgage payments, or received an eviction or foreclosure notice;

(b) You received a shut-off notice, were shut off, or were refused the delivery of essential utilities (gas, electric, oil, water, or telephone);

(c) You had non-cosmetic medical and/or dental out-of-pocket expenses (exclusive of premium payments), totaling more than 7.5% of your household's adjusted gross income that were not subject to payment by a third-party;

(d) You incurred a significant, unexpected increase in essential expenses resulting directly from the consequences of: (i) domestic violence; (ii) the death of a spouse, family member, or partner with primary responsibility for child care, where that spouse, family member, or partner shared household expenses with you; (iii) the sudden responsibility for providing full care for yourself, an aging parent or other family member, including a major, extended illness of a child that required a working parent to hire a full-time caretaker for the child; or (iv) a fire, flood, natural disaster, or other unexpected natural or human-caused event causing substantial household or personal damage for the individual filing the appeal.

(e) Your financial circumstances were such that the expense of purchasing health insurance would have caused you to experience a serious deprivation of food, shelter, clothing or other necessities.

(f) Your family size was so large that reliance on the affordability schedule (on page HC-7) to determine how much you could afford to pay for health insurance is inequitable.

You may also base your appeal on other circumstances, such as the application of the affordability tables in Schedule HC to you is inequitable (for example, due to fluctuation in income during the year), you were unable to obtain government-subsidized insurance despite your income, or other circumstances that made you unable to purchase insurance despite your income.

If you file an appeal, you will be required to state your grounds for appealing, and provide further information and supporting documentation. Any statements and claims you make will be under pains and penalties of perjury.

How to Appeal

To appeal, you must fill in the oval for you (and your spouse, if applicable) on Schedule HC, Appeals Section that authorizes DOR to share information in your tax return, including Schedule HC, with the Commonwealth Health Insurance Connector Authority, the independent state body that will hear the appeal. No penalty will be assessed by DOR pending the outcome of your appeal.

If you (and your spouse) fill in that oval on your return, you will receive a follow-up letter from the Connector Authority asking you to state your grounds for appeal in writing, and submit supporting documentation. **Failure to respond to that form within the time specified will lead to dismissal of your appeal.** The Connector Authority will then review the information you provided. You may be required to attend a hearing on your case. You will be required to state your claims under pains and penalties of perjury.

Note: Do not include any hardship documentation with your original return. You will be required to submit substantiating hardship documentation at a later date during the appeal process.

Important Health Insurance Information

Municipality	County
Abington	Plymouth
Acton	Middlesex
Acushnet	Bristol
Adams	Berkshire
Agawam	Hampden
Alford	Berkshire
Amesbury	Essex
Amherst	Hampshire
Andover	Essex
Arlington	Middlesex
Ashburnham	Worcester
Ashby	Middlesex
Ashfield	Franklin
Ashland	Middlesex
Athol	Worcester
Attleboro	Bristol
Auburn	Worcester
Avon	Norfolk
Ayer	Middlesex
Barnstable	Barnstable
Barre	Worcester
Becket	Berkshire
Bedford	Middlesex
Belchertown	Hampshire
Bellingham	Norfolk
Belmont	Middlesex
Berkley	Bristol
Berlin	Worcester
Bernardston	Franklin
Beverly	Essex
Billerica	Middlesex
Blackstone	Worcester
Blandford	Hampden
Bolton	Worcester
Boston	Suffolk
Bourne	Barnstable
Boxborough	Middlesex
Boxford	Essex
Boylston	Worcester
Braintree	Norfolk
Brewster	Barnstable
Bridgewater	Plymouth
Brimfield	Hampden
Brockton	Plymouth
Brookfield	Worcester
Brookline	Norfolk
Buckland	Franklin
Burlington	Middlesex
Cambridge	Middlesex
Canton	Norfolk
Carlisle	Middlesex
Carver	Plymouth
Charlemont	Franklin
Charlton	Worcester
Chatham	Barnstable
Chelmsford	Middlesex
Chelsea	Suffolk
Cheshire	Berkshire
Chester	Hampden
Chesterfield	Hampshire
Chicopee	Hampden
Chilmark	Dukes
Clarksburg	Berkshire
Clinton	Worcester
Cohasset	Norfolk
Colrain	Franklin
Concord	Middlesex
Conway	Franklin
Cummington	Hampshire
Dalton	Berkshire
Danvers	Essex
Dartmouth	Bristol
Dedham	Norfolk
Deerfield	Franklin
Dennis	Barnstable
Dighton	Bristol
Douglas	Worcester
Dover	Norfolk
Dracut	Middlesex
Dudley	Worcester
Dunstable	Middlesex
Duxbury	Plymouth
East Bridgewater	Plymouth
East Brookfield	Worcester
East Longmeadow	Hampden
Eastham	Barnstable
Easthampton	Hampshire
Easton	Bristol
Edgartown	Dukes
Egremont	Berkshire
Erving	Franklin
Essex	Essex
Everett	Middlesex
Fairhaven	Bristol
Fall River	Bristol
Falmouth	Barnstable
Fitchburg	Worcester
Florida	Berkshire
Foxborough	Norfolk
Framingham	Middlesex
Franklin	Norfolk
Freetown	Bristol
Gardner	Worcester
Gay Head	Dukes
Georgetown	Essex
Gill	Franklin
Gloucester	Essex
Goshen	Hampshire
Gosnold	Dukes
Grafton	Worcester
Granby	Hampshire
Granville	Hampden
Great Barrington	Berkshire
Greenfield	Franklin
Groton	Middlesex
Groveland	Essex
Hadley	Hampshire
Halifax	Plymouth
Hamilton	Essex
Hampden	Hampden
Hancock	Berkshire
Hanover	Plymouth
Hanson	Plymouth
Hardwick	Worcester
Harvard	Worcester
Harwich	Barnstable
Hatfield	Hampshire
Haverhill	Essex
Hawley	Franklin
Heath	Franklin
Hingham	Plymouth
Hinsdale	Berkshire
Holbrook	Norfolk
Holden	Worcester
Holland	Hampden
Holliston	Middlesex
Holyoke	Hampden
Hopedale	Worcester
Hopkinton	Middlesex
Hubbardston	Worcester
Hudson	Middlesex
Hull	Plymouth
Huntington	Hampshire
Ipswich	Essex
Kingston	Plymouth
Lakeville	Plymouth
Lancaster	Worcester
Lanesborough	Berkshire
Lawrence	Essex
Lee	Berkshire
Leicester	Worcester
Lenox	Berkshire
Leominster	Worcester
Leverett	Franklin
Lexington	Middlesex
Leyden	Franklin
Lincoln	Middlesex
Littleton	Middlesex
Longmeadow	Hampden
Lowell	Middlesex
Ludlow	Hampden
Lunenburg	Worcester
Lynn	Essex
Lynnfield	Essex
Malden	Middlesex
Manchester	Essex
Mansfield	Bristol
Marblehead	Essex
Marion	Plymouth
Marlborough	Middlesex
Marshfield	Plymouth
Mashpee	Barnstable
Mattapoisett	Plymouth
Maynard	Middlesex
Medfield	Norfolk
Medford	Middlesex
Medway	Norfolk
Melrose	Middlesex
Mendon	Worcester
Merrimac	Essex
Methuen	Essex
Middleborough	Plymouth
Middlefield	Hampshire
Middleton	Essex
Milford	Worcester
Millbury	Worcester
Millis	Norfolk
Millville	Worcester
Milton	Norfolk
Monroe	Franklin
Monson	Hampden
Montague	Franklin
Monterey	Berkshire
Montgomery	Hampden
Mount Washington	Berkshire
Nahant	Essex
Nantucket	Nantucket
Natick	Middlesex
Needham	Norfolk
New Ashford	Berkshire
New Bedford	Bristol
New Braintree	Worcester
New Marlborough	Berkshire
New Salem	Franklin
Newbury	Essex
Newburyport	Essex
Newton	Middlesex
Norfolk	Norfolk
North Adams	Berkshire
North Andover	Essex
North Attleborough	Bristol
North Brookfield	Worcester
North Reading	Middlesex
Northampton	Hampshire
Northborough	Worcester
Northbridge	Worcester
Northfield	Franklin
Norton	Bristol
Norwell	Plymouth
Norwood	Norfolk
Oak Bluffs	Dukes
Oakham	Worcester
Orange	Franklin
Orleans	Barnstable
Otis	Berkshire
Oxford	Worcester
Palmer	Hampden
Paxton	Worcester
Peabody	Essex
Pelham	Hampshire
Pembroke	Plymouth
Pepperell	Middlesex
Peru	Berkshire
Petersham	Worcester
Phillipston	Worcester
Pittsfield	Berkshire
Plainfield	Hampshire
Plainville	Norfolk
Plymouth	Plymouth
Plympton	Plymouth
Princeton	Worcester
Provincetown	Barnstable
Quincy	Norfolk
Randolph	Norfolk
Raynham	Bristol
Reading	Middlesex
Rehoboth	Bristol
Revere	Suffolk
Richmond	Berkshire
Rochester	Plymouth
Rockland	Plymouth
Rockport	Essex
Rowe	Franklin
Rowley	Essex
Royalston	Worcester
Russell	Hampden
Rutland	Worcester
Salem	Essex
Salisbury	Essex
Sandisfield	Berkshire
Sandwich	Barnstable
Saugus	Essex
Savoy	Berkshire
Scituate	Plymouth
Seekonk	Bristol
Sharon	Norfolk
Sheffield	Berkshire
Shelburne	Franklin
Sherborn	Middlesex
Shirley	Middlesex
Shrewsbury	Worcester
Shutesbury	Franklin
Somerset	Bristol
Somerville	Middlesex
South Hadley	Hampshire
Southampton	Hampshire
Southborough	Worcester
Southbridge	Worcester
Southwick	Hampden
Spencer	Worcester
Springfield	Hampden
Sterling	Worcester
Stockbridge	Berkshire
Stoneham	Middlesex
Stoughton	Norfolk
Stow	Middlesex
Sturbridge	Worcester
Sudbury	Middlesex
Sunderland	Franklin
Sutton	Worcester
Swampscott	Essex
Swansea	Bristol
Taunton	Bristol
Templeton	Worcester
Tewksbury	Middlesex
Tisbury	Dukes
Tolland	Hampden
Topsfield	Essex
Townsend	Middlesex
Truro	Barnstable
Tyngsborough	Middlesex
Tyringham	Berkshire
Upton	Worcester
Uxbridge	Worcester
Wakefield	Middlesex
Wales	Hampden
Walpole	Norfolk
Waltham	Middlesex
Ware	Hampshire
Wareham	Plymouth
Warren	Worcester
Warwick	Franklin
Washington	Berkshire
Watertown	Middlesex
Wayland	Middlesex
Webster	Worcester
Wellesley	Norfolk
Wellfleet	Barnstable
Wendell	Franklin
Wenham	Essex
West Boylston	Worcester
West Bridgewater	Plymouth
West Brookfield	Worcester
West Newbury	Essex
West Springfield	Hampden
West Stockbridge	Berkshire
West Tisbury	Dukes
Westborough	Worcester
Westfield	Hampden
Westford	Middlesex
Westhampton	Hampshire
Westminster	Worcester
Weston	Middlesex
Westport	Bristol
Westwood	Norfolk
Weymouth	Norfolk
Whately	Franklin
Whitman	Plymouth
Wilbraham	Hampden
Williamsburg	Hampshire
Williamstown	Berkshire
Wilmington	Middlesex
Winchendon	Worcester
Winchester	Middlesex
Windsor	Berkshire
Winthrop	Suffolk
Woburn	Middlesex
Worcester	Worcester
Worthington	Hampshire
Wrentham	Norfolk
Yarmouth	Barnstable

Section 4
Section 125 Plans

Fact Sheet: Section 125 Plan Requirement

Fact Sheet: Section 125 Plan Administration – General Information

Final Regulations – Section125 Plans

Connector Administrative Information Bulletin 02-07

Connector Administrative Information Bulletin 03-07

Associated Industries of Massachusetts

Fact Sheet

The Massachusetts Health Care Reform Law

Section 125 Plan Requirement

Status of Regulations: Final

Administrative Agency: The Connector

Effective Date: July 1, 2007

"Section 125" refers to a section of the Internal Revenue Service (IRS) code that governs federal tax treatment of many employee benefit plans. The Massachusetts health care reform law requires that employers of 11 or more full-time equivalent employees implement only one of the options available under Section 125 – a "premium only plan."

Premium only plans allow employees to pay insurance premiums on a pre-tax basis. The premium contributions are exempt from state and federal income taxes as well as Social Security and Medicare taxes. As a result, employees save, on average, 30 to 40 percent of the cost of the premium. Employers also realize a savings of 7.65% since they do not pay the employer share of Social Security and Medicare taxes on the premium amounts.

General Requirement

Employers with 11 or more full-time equivalent employees must:

1. Establish and maintain a compliant Section 125 premium only plan, and
2. Submit a copy of the plan to the Connector within seven (7) days of a request.

Failure to establish a compliant Section 125 plan potentially subjects the employer to a "free rider surcharge" if its employees and/or dependents access free care at levels defined in the free rider surcharge regulations. The surcharge would consist of some portion of the actual medical expenses incurred, which could result in very significant financial liability for the employer.

Employers that offer to pay 100% of the cost of insurance for all employees, both individual and family coverage, are not required to implement a Section 125 plan. This exclusion ends on the day that the employer ceases to pay 100% of the premium for all employees, or on the day the employer hires an employee who is not eligible for employer-sponsored coverage and who is not otherwise excludable from Section 125 plan eligibility under the regulations issued by the Connector.

Calculating the Total Number Of Employees

A "full-time equivalent" (FTE) employee is defined as 2,000 payroll hours per year. An employer is deemed to have 11 or more FTE employees if the sum of *total* payroll hours, including time paid but not worked, for all employees for the determination period divided by 2,000 is greater than or equal to 11. No more than 2,000 hours should be counted for any individual employee.

Definition of Employee

"Employee" includes all individuals employed at a Massachusetts location, whether or not they reside in Massachusetts. This includes full-time, part-time, temporary, and seasonal employees, including those who are members of unions. An "independent contractor", as defined in the Section 125 regulations, is not considered an employee.

Applicable Determination Period

An employer that reaches 11 or more employees during the determination period, October 1 through September 30 of each year, will be required to meet the Section 125 requirement by January 1 of the following calendar year.

Waiting Periods

The Section 125 plan waiting period for an employer-subsidized plan cannot extend beyond the waiting period for that health insurance plan.

The Section 125 plan waiting period for a plan that is not subsidized by the employer cannot exceed two months (i.e., March 20 to May 20 = two months).

Section 125 Cafeteria Plan Requirements

Under federal IRS rules, a written plan document is required and must contain at least the following six elements:

1. A specific description of each of the benefits available under the plan, including the periods during which the benefits are involved;
2. The plan's eligibility rules regarding participation;
3. The procedures governing participant elections under the plan;
4. The manner in which employer contributions may be made to the plan;
5. The maximum amount of elective employer contributions available to any participant under the plan either by stating the maximum dollar amount or maximum percentage of compensation that a participant may contribute; and
6. The plan year on which the cafeteria plan operates.

Employers must also be aware of reporting and disclosure requirements.

Employer Options

Under Massachusetts rules for compliance with health care reform, certain employees may be excluded from Section 125 plan participation if the employer so chooses. These include:

- Individuals under 18 years of age
- Temporary employees
- Part-time employees who average fewer than 64 hours per month
- Wait staff, service employees and service bartenders who average less than $400 in monthly payroll wages
- Student employees who are employed as interns or cooperative education students
- Employees whose employer is required to contribute to a multi-employer health plan based on their employment
- Seasonal workers with either a U.S. J-1 student visa, or a U.S. H2B visa who are also enrolled in travel health insurance
- Academic institutions may exclude student employees

A copy of the comprehensive Section 125 "Handbook for Employers" is included in the Appendix of this Guide.

Associated Industries of Massachusetts

Fact Sheet

The Massachusetts Health Care Reform Law

Section 125 Plan Administration – General Information

The premium conversion allowed by a Section 125 plan gives employees the option of paying their share of the cost of medical coverage with pre-tax dollars through salary reduction. The result is lower taxes for the employee and the employer since the premium contributions are exempt from Social Security and Medicare taxes as well as state and federal income taxes.

Section 125 plans are always subject to federal IRS regulations. As a result of the Massachusetts health care reform law, employers of 11 or more full-time equivalent employees must implement a Section 125 plan that also complies with a set of regulations issued by the Commonwealth Health Insurance Connector Authority (the Connector). It is important to note that simply having a plan document does not meet the guidelines established by the IRS. Employers must also ensure that eligible employees are able to make an educated decision about participation in the Section 125 plan and that the plan is administered according to the contents of its own plan document as well as IRS and Connector rules.

Plan Document: The employer must create a written plan document that, at a minimum, contains the following information:

- **Plan year** on which the plan operates. For administrative ease, it is recommended that the Section 125 plan year be the same as the plan year for the employer's group health plan.
- **Specific description of each of the benefits** available under the plan, including the periods during which the benefits are provided, i.e. the employer will need to specifically name which insurance plan(s) are available to employees who are eligible for the Section 125 plan.
- **Eligibility and participation rules**
  - Who is eligible?
  - When are they eligible? Under Connector regulations, the waiting period for employees who are eligible for employer-sponsored group coverage is the same as the waiting period for that coverage. For non-group employees who are eligible to participate in the Section 125 plan, the waiting period can be no longer than two months.
  - How long do eligible employees have to accept or decline participation once they become eligible?
- **Election periods** and the periods for which elections are effective, i.e., when will open enrollments occur? Elections are generally effective for the entire plan year except in special circumstances such as a short plan year or an approved mid-year election change.
- **Election changes:** A Section 125 plan may, but is not required to, allow an employee to revoke or change elections during a plan year only if the employee has had a "qualified change in status." The following are the events that meet this definition:
  - Change in legal marital status
  - Change in number of eligible dependents
  - Change in employment status (including becoming eligible or ceasing to become eligible for a benefit)
  - Change in an individual's dependent status
  - Change in place of residence
  - Change ordered by a judgment or decree
  - Employee's or dependent's entitlement to Medicare or Medicaid

- A change to the cost of coverage or to the coverage offered
- Special requirements related to leave taken under the federal Family and Medical Leave Act

The change allowed by an employer must be consistent with the nature of the change in status. For example, if a dependent ceases to meet the definition of eligible dependent, the only change that is allowed is the cancellation of coverage for that dependent, which may or may not impact the employee's cost.

The plan document must be maintained in the employer's records and submitted to the Connector within seven (7) days of a request. There is also no requirement to submit a copy of the plan document to the IRS except upon that agency's request.

Summary Plan Description (SPD): The employer must provide a summary plan description to each participant and each beneficiary in a plan regardless of whether a request has been made for the information. The SPD identifies the plan and describes its substance. It should be written so an employee can understand what he/she is eligible for.

In addition to providing an SPD to plan participants, employers may want to hold employee information sessions or prepare educational materials to inform employees on the details of a Section 125 plan and their eligibility to participate. Such materials would be useful when employees first become eligible and as part of the open enrollment communications process.

Plan Amendments: Employers amending an existing plan must, in some cases, distribute a summary of material modifications (SMM) to participants.

Summary Annual Report: A summary annual report containing information on the financial condition of the plan must be provided to participants after the conclusion of the plan year.

956 CMR: COMMONWEALTH HEALTH INSURANCE CONNECTOR AUTHORITY

956 CMR 4.00 EMPLOYER SPONSORED HEALTH INSURANCE ACCESS

Section 4.01 Authority

956 CMR 4.00 is promulgated in accordance with the authority granted to the Connector by M.G.L. c. 176Q, §16.

Section 4.02 Purpose

The purpose of 956 CMR 4.00 is to implement the provisions of M.G.L. c. 151F, which requires Employers with 11 or more Employees to (1) establish and maintain a Section 125 Cafeteria Plan in accordance with the rules and regulations promulgated by the Connector, and (2) file a copy of the Section 125 Cafeteria Plan with the Connector.

Section 4.03 Scope

956 CMR 4.00 contains the Connector's regulations governing the requirements of M.G.L. c. 151F. These regulations apply to all Employers with a total of 11 or more Employees at all locations within the Commonwealth of Massachusetts, regardless of whether any underlying medical care coverage accessed through a Section 125 Cafeteria Plan is maintained on an insured or self-insured basis, purchased on an individual or group basis, or provided through the Connector or through another distribution channel unrelated to the Connector.

Section 4.04 Effective Date

956 CMR 4.00 is effective on July 1, 2007.

Section 4.05 Definitions

As used in 956 CMR 4.00, unless the context otherwise requires, terms have the following meanings:

Client Company. A person, association, partnership, corporation or other entity that is a co-Employer of workers provided by an Employee Leasing Company pursuant to a contract.

Connector. The Commonwealth Health Insurance Connector established under M.G.L. c. 176Q.

Employee. Any individual employed by any Employer at a Massachusetts location, whether or not the individual is a Massachusetts resident.

Employee Leasing Company. 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.

Employer. An individual, partnership, association, corporation or other legal entity, or any two or more of the foregoing engaged in a joint enterprise, and including the legal representatives of a deceased employer, or the receiver or trustee of an individual, partnership, association, corporation or other legal entity, employing employees. Other legal entitities shall include, without limitation, the commonwealth, its instrumentalities, political subdivisions, an instrumentality of a political subdivision, including municipal hospitals, municipal electric companies, municipal water companies, regional school districts and any other instrumentalities as are financially independent and are created by statute.

Notwithstanding the preceding paragraph to the contrary, the owner of a dwelling house having not more than 3 apartments and who resides therein, or the occupant of a dwelling house of another who employs persons to do maintenance, construction or repair work on such dwelling house or on the grounds or buildings appurtenant thereto shall not because of such employment be deemed to be an employer. Further, the term "employer" shall neither include nonprofit entities, as defined by the Internal Revenue Code, which are exclusively staffed by volunteers, nor include sole proprietors.

Independent Contractor**.** An individual that provides services not deemed to be employment under M.G.L. c. 151A, § 2 because:

> (a) such individual has been and will continue to be free from control and direction in connection with the performance of such services, both under his contract for the performance of service and in fact; and
>
> (b) such service is performed either outside the usual course of the business for which the service is performed or is performed outside of all the places of business of the enterprise for which the service is performed; and

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

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

Seasonal Employee. An Employee who is a seasonal employee that works for an Employer that is a seasonal employer, as such terms are defined in M.G.L. c. 151A, section 1.

Section 125 Cafeteria Plan. A cafeteria plan that meets the requirements of Title 26, Subtitle A, Chapter 1, Subchapter B, Part III, Section 125 of the Internal Revenue Code.

Temporary Employee. An individual that works for an Employer on either a full or part time basis; whose employment is explicitly temporary in nature and does not exceed 12 consecutive weeks during the period from October 1 through September 30.

Section 4.06 Employers Subject to Chapter 151F

(1) General. An Employer is subject to the M.G.L. c. 151F requirement to adopt and maintain a Section 125 Cafeteria Plan in accordance with the rules of the Connector on and after the date, determined in accordance with 956 CMR 4.06(3), the Employer becomes a 151F Employer as determined in accordance with 956 CMR 4.06(2).

(2) 151F Employer. An Employer with 11 or more Employees during the applicable determination period, as determined in accordance with 956 CMR 4.06(3) shall become a Chapter 151F Employer as of the date set forth in 956 CMR 4.06(3).

(a) Number of Employees. An Employer has 11 or more Employees if the sum of total payroll hours for all Employees during the applicable determination period divided by 2,000 is greater than or equal to 11. In calculating total payroll hours:

1. For each Employee with more than 2000 payroll hours for the Employer, the Employer shall include 2000 payroll hours.

2. Payroll hours includes all hours for which an Employer paid wages as defined in M.G.L. c. 151A, section 1(s) to an Employee including, by way of example and not by way of limitation, regular, vacation, sick, paid Federal Medical Leave of Absence, short term disability, long term disability, overtime and holiday payroll hours.

3. An Employer who is determined to be a successor under M.G.L. c. 151A shall include the payroll hours of the predecessor's Employees during the applicable determination period.

(b) Employees. For purposes of this 956 CMR 4.06, Employees include, by way of example and not by way of limitation, full-time Employees, part-time Employees, Temporary Employees, and Seasonal Employees, regardless of whether his/her Employer is signatory to or obligated under a negotiated, bona fide collective bargaining agreement between such Employer and bona fide Employee representatives that governs the employment conditions of the Employee. Employees shall also include individuals who are considered self-employed for benefit plan purposes under Internal Revenue Code Section 401(c), but shall not include Independent Contractors.

(c) Multi-State Employer. A multi-state Employer with Massachusetts locations shall include all Employees employed at all Massachusetts locations in calculating total payroll hours.

(d) Certain Employee Leasing Arrangements. If and to the extent there is a co-employment arrangement between a Client Company and an Employee Leasing Company, the Client Company is the Employer for purposes of M.G.L. c. 151F with respect to those Employees covered under the co-employment arrangement. In the event the Client Company is determined to be a 151F Employer in accordance with 956 CMR 4.06(2), nothing in this 956 CMR 4.00 prohibits the Client Company from contractually allocating to the Employee Leasing Company the responsibility to adopt and/or maintain a Section 125 Cafeteria Plan for the benefit of the co-employed Employees, in accordance with 956 CMR 4.07, and to comply with the filing requirements in 956 CMR 4.08. However, if and to the extent that the Employee Leasing Company fails to comply with any such responsibilities contractually allocated to it, then the Client Company continues to have responsibility for compliance with this 956 CMR 4.00.

(e) Employers Providing Noncontributory Medical Coverage. Notwithstanding anything in this 956 CMR 4.06 to the contrary, an Employer will not be considered a 151F Employer if the Employer provides medical care coverage to and pays the full monthly cost of such medical care coverage (both individual coverage AND any dependent coverage to the extent elected by the Employee) for all of its Employees who are not otherwise excludable from a Section 125 Cafeteria Plan in accordance with 956 CMR 4.07(3)(b)4. This 956 CMR 4.06(2)(e) shall cease to apply on the date the Employer ceases to provide medical care coverage to or ceases to pay the full monthly cost of that medical care coverage for all of its Employees who are not otherwise excludable from a Section 125 Cafeteria Plan in accordance with 956 CMR 4.07(3)(b)4) (the "cessation date"). The Employer shall then determine its status as a 151F Employer in accordance with this 956 CMR 4.06 beginning with the April 1 determination date coincident with or next following the cessation date.

In no event shall any reference to the full monthly cost of medical care coverage in this 956 CMR 4.06(e) be construed to include any deductible, coinsurance, copayment or other cost-sharing amounts that are the responsibility of the Employee under the applicable medical care coverage.

(3) Applicable Determination Period

(a) Initial Determination Period. The initial determination period shall be the 12 consecutive month period beginning April 1, 2006 and ending March 31, 2007. An Employer with 11 or more Employees during the initial determination period, as determined in accordance with 956 CMR 4.06(2), shall become a 151F Employer effective July 1, 2007.

(b) Subsequent Determination Periods. For those Employers who do not have 11 or more Employees during the initial determination period (or a subsequent determination period, as applicable), as determined in accordance with 956 CMR 4.06(2), October 1, 2007 and each October 1 thereafter will be considered a new determination date for any Employer with less than 11 Employees during the preceding determination period. The applicable subsequent determination period for each October 1 determination date shall be the 12 consecutive month period ending on the September 30 immediately preceding the October 1 determination date. An Employer with 11 or more Employees during a subsequent determination period, as determined in accordance with 956 CMR 4.06(2), shall become a 151F Employer effective on the first day of January following the corresponding October 1 determination date.

Section 4.07 Adoption and Maintenance of Section 125 Cafeteria Plan

(1) General. Pursuant to M.G.L. c. 151F, a 151F Employer is required to adopt and maintain a Section 125 Cafeteria Plan in accordance with regulations and rules promulgated by the Connector. A Section 125 Cafeteria Plan must meet the requirements of 956 CMR 4.07(2) and (3) and must be adopted and maintained by the 151F Employer as described in 956 CMR 4.07(4) and (5) respectively. A 151F Employer shall not be in compliance with M.G.L. c. 151F if and to the extent its Section 125 Cafeteria Plan fails to satisfy this 956 CMR 4.07.

(2) Section 125 Cafeteria Plan Requirements. A Section 125 Cafeteria Plan must satisfy applicable Internal Revenue Code Section 125 requirements, any applicable U.S. Treasury Department rulings, regulations and guidance, as determined by the Internal Revenue Service, and shall include:

(a) Written Plan Document. A Section 125 Cafeteria Plan must consist of a written plan document containing at least the following six elements.

1. A specific description of each of the benefits available under the plan, including the periods during which the benefits are provided. The benefit description need not be self-contained.

Benefits described in other separate written plans may be incorporated by reference into the plan document.

2. The plan's eligibility rules regarding participation.
3. The procedures governing participant elections under the plan, including the period during which elections may be made, the extent to which elections are irrevocable, and the periods with respect to which the elections are effective.
4. The manner in which Employer contributions may be made to the plan, such as by salary reduction agreement between the participant and Employer or by non-elective Employer contributions to the plan.
5. The maximum amount of elective Employer contributions available to any participant under the plan either by stating the maximum dollar amount or maximum percentage of compensation that a participant may contribute, or by stating the method for determining the maximum amount or percentage.
6. The plan year on which the cafeteria plan operates.

(3) Connector Requirements. In addition, a Section 125 Cafeteria Plan must comply with the following minimum Connector requirements in order to comply with M.G.L. c. 151F:

(a) Premium Only Plan. A Section 125 Cafeteria Plan must, at a minimum, be a premium only plan offering access to one or more medical care coverage options to each eligible Employee in lieu of regular cash compensation.

1. Section 125 Cafeteria Plans that function as flexible spending account only plans, or as premium only plans offering access to benefit options that do not include access to any medical care coverage options will not satisfy this 956 CMR 4.07(3).
2. Flexible spending accounts are not required to be offered as a coverage option.

(b) Eligibility for Participation. In connection with a Section 125 Cafeteria Plan offered by a 151F Employer:

1. Employee eligibility requirements for participation in a Section 125 Cafeteria Plan of a 151F Employer (and the extent of such participation) shall be established by the applicable 151F Employer and shall be clearly set forth in its written Section 125 Cafeteria Plan document.
2. A 151F Employer may provide for an eligibility waiting period in its Section 125 Cafeteria Plan. Such a Section 125 Cafeteria Plan eligibility waiting period will be considered in compliance with M.G.L. c. 151F if the eligibility waiting period:
   a. corresponds with (and does not exceed) the eligibility waiting period for enrollment in the applicable medical care coverage option(s) available to the eligible Employee under

the Section 125 Cafeteria Plan provided the 151F Employer makes contributions toward such coverage; or

b. does not exceed 2 months (e.g., March 1 to May 1; or March 20 to May 20 is considered two months) if the 151F Employer makes no contribution toward the applicable medical care coverage option(s) available to the eligible Employee under the Section 125 Cafeteria Plan.

Notwithstanding the foregoing to the contrary, those Employers that have 151F status as of July 1, 2007 may provide for a special initial eligibility waiting period in a Section 125 Cafeteria Plan for those eligible Employees who are employed on July 1, 2007 that may extend to no later than September 1, 2007.

3. An eligible Employee must be offered participation in the Section 125 Cafeteria Plan during any applicable election periods provided for in the written Section 125 Cafeteria Plan document, without regard to whether the eligible Employee was previously eligible or had previously waived participation in the Section 125 Cafeteria Plan during any prior election period.

4. Notwithstanding anything in this 956 CMR 4.00 to the contrary, a 151F Employer may specifically exclude from eligibility to participate in its Section 125 Cafeteria Plan the following classes of Employees without being considered not in compliance with M.G.L. c. 151F with respect to such Employees:

    a. Employees who are less than 18 years of age
    b. Temporary Employees
    c. Part-time Employees working, on average, fewer than 64 hours per month for an Employer
    d. Employees who are considered wait staff, service employees or service bartenders (as defined in M.G.L. c. 149, section 152A) and who earn, on average, less than $400 in monthly payroll wages
    e. Student Employees who are employed as interns or as cooperative education student workers
    f. Employees whose Employer is required to contribute to a Multiemployer Health Benefit Plan based on their employment
    g. 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.

(c) No Employer Contributions Required. All contributions made in connection with medical care coverage options offered under a Section

125 Cafeteria Plan may be made solely by Employee salary reduction. Non-elective Employer contributions to the Section 125 Cafeteria Plan are not required.

(d) Plan Document Configuration. The Section 125 Cafeteria Plan document may be a separate, stand-alone document or combined/consolidated with other employer-provided plans. A 151F Employer may utilize more than one Section 125 Cafeteria Plan document to provide its Employees with access to medical care coverage options, including a plan established solely for Employees not otherwise eligible for the 151F Employer's subsidized medical care coverage options.

(e) Affiliated/Participating Employers. Nothing in this regulation is intended to restrict Section 125 Cafeteria Plan documents from covering Employees of two or more 151F Employers to the extent the Employers are affiliated/related to one another. The plan documentation should clearly identify all participating employers.

(4) Plan Adoption. Each 151F Employer shall take such actions as it deems necessary or appropriate to adopt its Section 125 Cafeteria Plan(s) in accordance with its own internal governance procedures and with applicable law, regardless of whether the Section 125 Cafeteria Plan is intended to be a newly established plan, a plan amendment to an existing plan or an amended and restated plan.

(a) Plan Effective Date. The written plan documentation must clearly state the effective date of the Section 125 Cafeteria Plan (or, if applicable, the effective date of any subsequent plan amendment or restatement intended to conform the Section 125 Cafeteria Plan to M.G.L. c. 151F), which shall be no later than the date the Employer became a 151F Employer, as determined in accordance with 956 CMR 4.06.

(b) Affiliated/Participating Employers. Each 151F Employer who is a participating Employer in an affiliated/related Employer's Code Section 125 Cafeteria Plan shall take such actions as it deems necessary or appropriate to adopt such Section 125 Cafeteria Plan(s) in accordance with its own internal governance procedures and with applicable law.

(5) Plan Maintenance. A Section 151F Employer shall be deemed to maintain a Section 125 Cafeteria Plan as required by M.G.L. c. 151F if the plan meets the Cafeteria Plan requirements in 956 CMR 4.07 (2), the Connector requirements in 956 CMR 4.07(3), has been adopted in accordance with 956 CMR 4.07 (4), and has not been subsequently terminated by the 151F Employer.

Section 4.08 Filing Section 125 Cafeteria Plan Documents

(1) General. Pursuant to M.G.L. c. 151F, a 151F Employer is required to file a copy of its Section 125 Cafeteria Plan(s) with the Connector.

(2) Filing Requirements.

(a) Each 151F Employer shall submit a copy of its Section 125 Cafeteria Plan(s) to the Connector, or its designee, on or before the effective date of its 151F Employer status. Any Section 125 Cafeteria Plan maintained by a 151F Employer that is not available to any Employees employed at a Massachusetts location is not subject to the filing requirement and need not be submitted to the Connector.

(b) Each submission shall be in the form and manner specified by the Connector and shall include such other documentation related to the 151F Employer's Section 125 Cafeteria Plan as the Connector may from time to time require.

(c) An Employer must designate a responsible individual authorized to verify and certify the accuracy of the documentation submitted.

(d) The Connector may change the filing requirements, including specified forms and filing deadlines, by administrative bulletin.

Section 4.09 Other Provisions

(1) Compliance Enforcement. Compliance with M.G.L. c. 151F and this 956 CMR 4.00 will be enforced by the attorney general. Noncompliance may subject a 151F Employer to the Employer Surcharge for State-Funded Health Costs described in M.G.L. c. 118G and any regulations promulgated thereunder, as amended from time to time

(2) Consistency with Section 125. The Connector intends that these regulations neither be inconsistent with Internal Revenue Code Section 125, nor require any Employer to take any action that would violate Internal Revenue Code Section 125.

(3) No ERISA Plan. In general, a Section 125 Cafeteria Plan is not an ERISA welfare benefit plan and nothing in these regulations is intended to require any Employer to establish an ERISA welfare benefit plan.

(4) Administrative Information Bulletins. The Connector may issue administrative information bulletins to clarify policies, update administrative requirements and specify information and documentation necessary to implement 956 CMR 4.00.

(5) Severability. The provisions of 956 CMR 4.00 are severable. If any provision or the application of any provision is held to be invalid or unconstitutional, such invalidity shall not be construed to affect the validity or constitutionality of any remaining provisions of 956 CMR 4.00 or the application of such provisions.

REGULATORY AUTHORITY

956 CMR 4.00; M.G.L. c. 176Q.

Section 125 Regulations
Administrative Information Bulletin #02-07
Issued by the Connector - Effective June 29, 2007

Administrative Information Bulletin 02-07:

Guidance Regarding M.G.L. c. 151F, as implemented by 956 CMR 4.00

June 29, 2007

Pursuant to 956 CMR 4.08(4), the Commonwealth Health Insurance Connector Authority (the "Connector") is issuing this Administrative Information Bulletin ("Bulletin") to provide guidance in connection with the section 125 cafeteria plan requirement set forth in M.G.L. c. 151F and 956 CMR 4.00. The Bulletin provides (a) administrative information concerning the filing of employer-maintained section 125 cafeteria plan documents with the Connector under 956 CMR 4.07; and (b) clarification related to certain classes of employees that are excludable from participation in an employer's section 125 cafeteria plan in accordance with 956 CMR 4.06.

(1) Filing Section 125 Cafeteria Plan Documents

(a) Postponement of Filing Deadline. Pursuant to M.G.L. c. 151F and 956 CMR 4.07, an employer is required to file a copy of its section 125 cafeteria plan(s) with the Connector, or its designee, on or before the effective date of the employer's status as a 151F Employer. For employers with 11 or more full-time equivalent employees during the initial determination period ending March 31, 2007, who qualify as 151F Employers, the filing deadline has been set at July 1, 2007. In accordance with 956 CMR 4.07 (2)(c), by this administrative bulletin the Connector is postponing the filing deadline for those section 125 cafeteria plan documents due to be filed on or before July 1, 2007 until **October 1, 2007**. Further, the Connector will not accept section 125 cafeteria plan documents prior to September 1, 2007.

(b) Filing Upon Request of the Connector. During the period of postponement between July 1, 2007 and October 1, 2007, a 151F Employer shall, upon request of the Connector, submit a copy of its section 125 cafeteria plan(s) to the Connector in the time and manner specified by the Connector.

(2) Definition of Employee. An employee, as defined in 956 CMR 4.04, is revised as follows: An individual employed by any Employer at a Massachusetts location, whether or not the individual is a Massachusetts resident. **For purposes of counting the number of employees in 956 CMR 4.05(2), an employee referred to in 956 CMR 4.05(2)(b) shall not include an individual employed for less than one month.**

(3) Defining Excludable, Part-time Employees. In accordance with 956 CMR 4.06 (3)(b), a 151F Employer may, at its option, specifically exclude from eligibility to participate in its section 125 cafeteria plan one, none, or any combination of the specified employee classes and still be compliant with M.G.L. c. 151F with respect to such excluded employees. 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 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.

c. Example. Paul is hired as a part-time employee and commences employment on September 15, 2007. His employer's section 125 plan excludes from eligibility part-time employees working, on average, less than 64 hours per month. At the time of hire, Paul's employer reasonably anticipates that Paul will work an average of at least 65 hours per month; making Paul eligible for the employer's section 125 plan which operates on a July 1 fiscal year and facilitates the purchase of Connector seal of approval policies from the Connector on a pre- tax basis. Open enrollment for the section 125 plan will begin May 1, 2008 for the next plan year beginning July 1, 2008.
    - Assuming he is employed for the duration, Paul will be considered a new hire until April 30, 2008 (the later of X and Y in subparagraph b. above) and any election made by Paul when hired will remain in effect until the end of the plan year (June 30, 2008), regardless of actual hours worked per month during that period.
    - If Paul wishes to re-enroll for pre-tax benefits for the new plan year, his employer can redetermine his eligibility by averaging Paul's hours worked during the 180 days preceding May 1, 2008.

(4) Wait staff tips exclusion: Employers may exclude from participation in a Section 125 plan those employees who are considered wait staff, service employees or service bartenders (as defined in M.G.L. c. 149, section 152A) who earn, on average, less than $400 in monthly payroll wages. Employers should not include tips when calculating whether an individual's wages exceed $400 monthly for purposes of determining whether employees fall within this exclusion. Tips mean a sum of money, including any amount designated by a credit card patron, a gift or a gratuity, given as an acknowledgment of any service performed by a wait staff employee, service employee, or service bartender.

(5) 64 Hour Part-time Threshold. If an employer excludes part-time employees based on an hours per month classification, as permitted in 956 CMR 4.00, that employer may not exclude from eligibility part-time employees working, on average, 64 or more hours per month. An employer may, however, adopt an hourly threshold for part-time, excludable employees that fall bellows the standard of 64 hours per month (e.g., 32 hours per month).

This Administrative Bulletin takes effect immediately.

Administrative Information Bulletin 03-07:

Guidance Regarding M.G.L. c. 151F, as implemented by 956 CMR 4.00

September 5, 2007

Pursuant to 956 CMR 4.08(4), the Commonwealth Health Insurance Connector Authority (the "Connector") is issuing this Administrative Information Bulletin ("Bulletin") to provide guidance in connection with the section 125 cafeteria plan requirement set forth in M.G.L. c. 151F and 956 CMR 4.00. The Bulletin provides guidance concerning (a) the filing of employer-maintained section 125 cafeteria plan documents with the Connector under 956 CMR 4.07, (b) certain classes of employees that are excludable from participation in an employer's section 125 cafeteria plan in accordance with 956 CMR 4.06, and (c) definitions in 956 CMR 4.04.

(1) Revised Section 125 Cafeteria Plan Filing Requirement. In accordance with 956 CMR 4.07 (2)(d), by this Bulletin the Connector is revising the filing requirement stated in 956 CMR 4.07 (2)(a), effective September 1, 2007, to provide as follows:
Each 151F Employer shall, upon the request of the Connector, submit a copy of its Section 125 Cafeteria Plan(s) to the Connector within seven (7) business days of the Connector's request. Any Section 125 Cafeteria Plan maintained by a 151F Employer that is not available to any Employees employed at a Massachusetts location is not subject to the filing requirement.
The remainder of 956 CMR 4.07(2) is not modified by this Bulletin and shall remain in full force and effect. Paragraph (1) of Connector Administrative Information Bulletin 02-07 is superseded by this Bulletin, effective September 1, 2007.

(2) Certain Student Employees as an Excludable Class. In accordance with 956 CMR 4.06 (3)(b), a 151F Employer may, at its option, specifically exclude from eligibility to participate in its section 125 cafeteria plan one, none, or any combination of the specified employee classes and still be compliant with M.G.L. c. 151F with respect to such excluded employees. 956 CMR 4.06(3)(b) is revised to add the following class of employees to the list of excludable classes as 4.06(3)(b)h:
h. 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 (i.e., section 18 of MGL c. 15A or a qualifying student health insurance program of another state) or in a health plan with comparable coverage, as required by state law.

(3) Definition of Independent Contractor. Independent Contractor, as defined in 956 CMR 4.04, is revised as follows:
An individual that provides services not deemed to be employment under M.G.L. c. 151A, § 2 because:

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

(b) such service is performed either outside the usual course of the business for which the service is performed or is performed outside of all the places of business of the enterprise for which the service is performed; and

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

Independent Contractor shall also include an individual who provides services not deemed to be employment for federal employment tax and wage withholding purposes in accordance with Internal Revenue Code sections 3121 and 3401 and with the 20-factor test established by Internal Revenue Service Rev. Rul. 87-41.

This Administrative Bulletin takes effect immediately.

Section 5
Free Rider Surcharge

Fact Sheet: Free Rider Surcharge

Final Regulations – Free Rider Surcharge

Associated Industries of Massachusetts

Fact Sheet

The Massachusetts Health Care Reform Law

Free Rider Surcharge

Status of Regulations:	Final
Administrative Agency:	Division of Health Care Finance and Policy (DHCFP)
Effective Date:	July 1, 2007

General Purpose of Free Rider Surcharge

A surcharge may be assessed on employers that fail to establish a compliant Section 125 payroll deduction program for pre-tax payment of health insurance premiums. The surcharge will help pay for state-funded health care costs incurred by employees and/or dependents.

Employers without compliant Section 125 plans may be subject to the Free Rider Surcharge if:

- The employer has 11 or more full-time equivalent employees, AND
  - ✓ The employer does not have a compliant Section 125 premium only plan;
  - ✓ The employer has employees and/or dependents who are "state funded employees" as defined by the regulations; and
  - ✓ Those employees and/or dependents receive a total of $50,000 or more in state funded health services.

No surcharge is applied for services utilized during any eligibility waiting period as long as a compliant Section 125 plan has been implemented.

Calculating the total number of employees

An employer has 11 or more full-time equivalent employees if the sum of *total* payroll hours, including time paid but not worked, for all employees for the period from October 1 through September 30 divided by 2,000 is greater than or equal to 11. No more than 2,000 hours should be counted for any single individual.

Determination of surcharge amount

The DHCFP will determine the surcharge based on:

1. The number of employees of the employer
2. The number of admissions and visits for each state funded employee
3. The total state funded health services attributed to the employer's state funded employees
4. The percentage of employees for whom the employer provides health insurance.

Notification of Surcharge Liability

The DHCFP will notify employers subject to surcharge at the end of each fiscal year.

114.5 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.5 CMR 17.00 EMPLOYER SURCHARGE FOR STATE FUNDED HEALTH COSTS

17.01 General Provisions

(1) Scope and Purpose. 114.5 CMR 17.00 governs the surcharge assessed on Employers that do not comply with the requirements of M.G.L. c. 151F to adopt and maintain a Section 125 Cafeteria Plan for payroll deductions for health insurance premiums in accordance with Commonwealth Health Insurance Connector regulations at 956 CMR 4.00. The surcharge is assessed for State Funded Health Costs incurred for its Employees or Employee Dependents not offered participation in the Employer's Section 125 Cafeteria Plan.

(2) Authority: 114.5 CMR 17.00 is adopted pursuant to M.G.L. c. 118G, § 18B.

(3) Effective Date. 114.5 CMR 17.00 is effective on July 1, 2007.

17.02 Definitions

Meaning of Terms: As used in 114.5 CMR 17.00, unless the context otherwise requires, terms have the following meanings:

Client Company. A person, association, partnership, corporation or other entity that uses workers provided by an Employee Leasing Company pursuant to a contract.

Commonwealth Care Trust Fund. The trust fund established under M.G.L. c. 29, § 2OOO.

Connector. The Commonwealth Health Insurance Connector established under M.G.L. c. 176Q.

Dependent. A spouse and any individual that meets the criteria defined in Title 26, Subtitle A, Chapter 1, Subchapter B, Part V, Section 152 of the Internal Revenue Code.

Division. The Division of Health Care Finance and Policy established under M.G.L. c. 118G or its designated agent.

Employee. An individual employed by any Employer at a Massachusetts location, whether or not the individual is a Massachusetts resident, for at least one month.

Employee Leasing Company. 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.

Employer. An Employer with more than eleven full time equivalent Employees that is required by M.G.L. c. 151F to adopt and maintain a Section 125 Cafeteria Plan in accordance with the provisions of 956 CMR 4.06.

Fiscal Year. The period from October 1 through September 30, the fiscal year for the Uncompensated Care Trust Fund and Health Safety Net Trust Fund..

Free Care. Services eligible for payment from the Uncompensated Care Trust Fund under 114.6 CMR 11.00 and 114.6 CMR 12.00 and from its successor, the Health Safety Net Trust Fund.

Health Insurance Responsibility Disclosure (HIRD). The form that Employers and Employees are required to submit about health insurance status under M.G.L. c. 118G, § 6C and 114.5 CMR 18.00.

Health Safety Net Trust Fund. The trust fund established pursuant to M.G.L. c. 118E, 57.

Insurance Partnership Program. The premium assistance program established under M.G.L. c. 118E, § 9C.

Section 125 Plan. A cafeteria plan that meets the criteria defined in Title 26, Subtitle A, Chapter 1, Subchapter B, Part III, Section 125 of the Internal Revenue Code.

State funded Health Services. Services that are paid from the Uncompensated Care Trust Fund or the Health Safety Net Trust Fund as further defined in 114.5 CMR 17.03(4).

Uncompensated Care Trust Fund. The fund established pursuant to M.G.L. c. 118G, § 18.

17.03 Employers Subject to Surcharge.

(1) General. An Employer is subject to surcharge if

(a) it is a Non-Providing Employer determined in accordance with 114.5 CMR 17.03(2); and

(b) any of its Employees are State funded Employees determined in accordance with 114.5 CMR 17.03(3); and

(c) its State funded Employees receive State funded Health Services that total at least $50,000 in a fiscal year as determined in accordance with 114.5 CMR 17.03(4).

(2) Non-Providing Employer. A Non-Providing Employer is an Employer of a State funded Employee as defined in 114.5 CMR 17.03 (3) that employs eleven or more full time equivalent Employees and is not in compliance with the requirement to adopt and maintain a Section 125 Cafeteria Plan for such State funded Employee.

(a) Number of Employees. An Employer has eleven or more full time equivalent Employees if the sum of total payroll hours for all Employees for the Fiscal Year divided by 2,000 is greater than or equal to 11. In calculating total payroll hours:

1. For each Employee with more than 2,000 payroll hours for the Employer, the Employer shall include 2,000 payroll hours.
2. Payroll hours include all hours for which an Employer paid wages to an Employee including, but not limited to, regular, vacation, sick, Federal Medical Leave of Absence, short term disability, long term disability, overtime and holiday payroll hours.
3. An Employer that is determined to be a successor under M.G.L. c. 151A shall include the payroll hours of the precessor's Employees during the applicable Fiscal Year.

(b) Certain Permitted Section 125 Cafeteria Plan Exclusions. An Employer is not a Non-Providing Employer with respect to a State funded Employee to the extent the Employee is excluded from eligibility to participate in the Employer's Section 125 Cafeteria Plan in accorance with 956 CMR 4.00.

(c) Exemptions. An Employer is not a Non-Providing Employer if it is a signatory to or obligated under a negotiated, bona fide collective bargaining agreement that governs the employment conditions of the State funded Employee; or participates in the Insurance Partnership Program.

(d) Employee Leasing Company Arrangements. If and to the extent there is an arrangement between Client Company and an Employee Leasing Company, the Client Company is the Employer for purposes of M.G.L. c. 118G and the determination of the Employer Surcharge under 114.5 CMR 17.00 with respect to itself and its Employees covered by the arrangement.

(3) State funded Employee. A State funded Employee is

(a) an Employee or Dependent of such Employee with more than three State funded admissions or visits during a Fiscal Year, or

(b) an Employee or Dependent of an Employee of an Employer whose Employees or Dependents make five or more State funded admissions or visits during a Fiscal Year.

(4) Determination of State funded Health Costs. The Division will determine the State funded Health Costs for a State funded Employee as follows:

(a) The Division will review all claims for State funded Health Services submitted for payment by hospitals and community health centers during a Fiscal Year.

(b) The Division will match claims to Employers, using all available data sources, including, but not limited to, the Employee’s application form, the provider claim or Emergency Room Bad Debt Form, the HIRD form, Office of Medicaid data, and data from the Department of Revenue and Division of Unemployment Assistance

(c) For each Fiscal Year, the Division will determine State funded Health Costs by multiplying each provider's claims for State funded Health Services by its percentage of total Uncompensated Care Pool or Safety Net Care payments divided by its total charges for all State funded Health Services.

(d) The Division will determine the Employers of State funded Employee(s) as set forth in 114.5 CMR 17.03(3) and with $50,000 or more in aggregate State funded Health Services.

(e) The Division will determine if an Employer identified in paragraph 4 above is a Non-Providing Employer. The Division will make this determination using data from the HIRD form, the Connector, and data matches undertaken pursuant to an Interagency Service Agreement to the extent permitted by law with the Department of Revenue and the Division of Unemployment Assistance.
(f) FY2007. For FY2007, the Division will determine State funded Health Costs only for the period from July 1, 2007 through September 30, 2007.

(5) Monitoring: The Division may use data submitted by hospitals and community health centers to monitor uncompensated care usage during the fiscal year and may inform Employers if it determines that its State funded Employees have incurred State funded Health Costs in a fiscal year.

17.04 Determination of Surcharge Amount

(1) General. The Division will determine the Surcharge amount by taking into account
(a) the number of Employees of the Employer;
(b) the number of admissions and visits for each State funded Employee;
(c) the total State funded Health Services attributed to the Employer's State Funded Employees as determined under 114.5 CMR 17.03(4); and
(d) the percentage of Employees for whom the Employer provides health insurance.

(2) Employer Category.
(a) The Division will assign each Employer subject to surcharge to one of three categories as follows:

Category 1	11-25 Employees
Category 2	26-50 Employees
Category 3	>50 Employees

(b) The Division will determine the number of full time equivalent Employees using the best available data including data from the Department of Revenue and the Division of Unemployment Assistance.

(3) Assessment Percentage. The Division will determine the percentage of State funded Health Costs to be assessed in accordance with the Table in 114.5 CMR 17.04(4). The percentages in the Table are based on the number of Employees and the amount of State-Fund Health Costs incurred.

(4) Surcharge Determination. The Division will apply the surcharge in the chart below to an Employer's State funded Health Costs when (1) one State Funded Employee or his or her Dependents has 4 or more admissions or visits during the year, or (2) its State Funded Employees and/or their Dependents have 5 or more visits during the year.

The product of the State Funded Health Costs and the applicable percentage will be reduced by the Employer's percentage of Enrolled Employees as determined under 114.5 CMR 16.03 (a). However, in no case shall the reduction be greater than 75%.

State Funded Costs	11-25 Employees	26-50 Employees	>50 Employees
$50,000-$75,000	20%	50%	80%
$75,001-$150,000	30%	60%	90%
Over $150,000	40%	70%	100%

17.05 Collection of Surcharge

(1) Notification of Surcharge Liability. The Division will notify Employers subject to Surcharge at the end of each Fiscal Year. The Notice will contain the following information.

(a) Employer name, FEIN, address
(b) Name of State funded Employee. If Employee dependent, name of Employee
(c) Name of provider that submitted claim
(d) Dates of service
(e) Provider charges
(f) Amount of State funded Health Costs per State funded Employee
(g) Total Amount of State funded Health Costs
(h) Surcharge Amount determined in accordance with 114.5 CMR 17.04
(i) Date payment is due
(j) Remittance advice with directions to submit payment

(2) If a State funded Employee is employed by more than one Non-Providing Employer at the time State funded Health Services are delivered, the Division will assess a prorated Surcharge to each Employer based on the best available data. If an individual is a Dependent of two State funded Employees, the Division will assess a prorated Surcharge to each Employer.

(3) Review. An Employer may challenge the Division'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 Employer.

(a) The Employer must notify the Division in writing within 14 days of the notice that it contests the Division's determination. The Employer must submit documentation to support its claim with its notification.
(b) The Division will review the documentation and make a determination based on its review of the documentation submitted and any other available data. The Division will issue a written decision explaining its determination and any adjustment to the Employer Surcharge amount.
(c) If the Division determines upon review that the Employer is not a Non-Providing Employer or is not otherwise responsible for the State funded Health Costs, no surcharge will be assessed.
(d) If the Division does not adjust the Surcharge amount upon review, payment is due within seven days of the notification of the Division's decision. If the Division adjusts the Surcharge amount upon review, payment is due within fourteen days of the Division's decision.

(4) Penalties for nonpayment or late payment by the non-providing Employer, including assessment of interest on the unpaid liability at a rate not to exceed an annual percentage rate of 18 per cent and late fees or penalties at a rate not to exceed 5 per cent per month.

(5) In the case of a transfer of ownership, a Non-Providing Employer's surcharge liability shall be assumed by the successor in interest to the Non-Providing Employer.

(f) All surcharge payments made under this Section shall be deposited into the Commonwealth Care Trust Fund, established by section 2OOO of chapter 29.

17.06 Other Provisions

(1) No Employer shall discriminate against any Employee on the basis of the Employee's receipt of free care, the Employee's reporting or disclosure of his Employer's identity and other information about the Employer, the Employee's completion of a Health Insurance Responsibility Disclosure form, or any facts or circumstances relating to "free rider" surcharges assessed against the Employer in relation to the Employee. Violation of this subsection shall constitute a per se violation of chapter 93A.

(2) Reporting Requirements. Each Employer shall file or make available information which is required or which the Division deems reasonably necessary for calculating and collecting the Employer Surcharge.

(3) Notice Requirements. An acute hospital or community health center will include a notice in all written Collection Actions that the Division may provide information about state funded services to Employers and that Employers may be liable for services Employees receive.

(4) Penalties. If an Employer fails to file any data, statistics or schedules or other information required under this chapter or by any regulation promulgated by the division, the division shall provide written notice of the required information. If the Employer fails to provide information within 2 weeks of receipt of said notice, or if it falsifies the same, it shall be subject to a civil penalty of not more than $5,000 for each week on which such violation occurs or continues, which penalty may be assessed in an action brought on behalf of the commonwealth in any court of competent jurisdiction.

(5) Administrative Information Bulletins. The Division may issue administrative information bulletins to clarify policies, update administrative requirements and specify information and documentation necessary to implement 114.5 CMR 17.00.

(6) Severability. The provisions of 114.5 CMR 17.00 are severable. If any provision or the application of any provision is held to be invalid or unconstitutional, such invalidity shall not be construed to affect the validity or constitutionality of any remaining provisions of 114.5 CMR 17.00 or the application of such provisions.

REGULATORY AUTHORITY

114.5 CMR 17.00 M.G.L. c. 118G.

Section 6
Fair Share Contributions

Fact Sheet: Fair Share Contribution Obligation

Fact Sheet: Fair Share Contribution – Compliance Information

Final Regulations – Fair Share Contribution

Final Regulations – Fair Share Compliance Filing

Associated Industries of Massachusetts

Fact Sheet

The Massachusetts Health Care Reform Law

Fair Share Contribution Obligation

Status of Regulations: Final

Administrative Agencies: Division of Health Care Finance and Policy (DHCFP)
Division of Unemployment Assistance (DUA)

Effective Date: September 30, 2008 as revised

General Purpose of Fair Share Contribution

The fair share contribution obligation requires employers of eleven or more full-time-equivalent (FTE) employees to make a "fair and reasonable" contribution toward the cost of health insurance for their employers. Failure to comply with this obligation results in a financial penalty, statutorily limited to a maximum of $295 per FTE employee per year, which goes toward the funding of the state's Health Care Safety Net (free care).

Contrary to some interpretations, the concept is not a mandate that an organization provide group insurance, but is designed to "level the playing field" among employers. Those who do provide group health insurance have long paid a premium surcharge to the state to help pay for free care. Employers who did not offer coverage, or who contributed nothing or very little toward the cost, bore none, or very little, of the free care burden.

Determination of Fair and Reasonable Premium Contribution

Compliance with the fair share contribution obligation is determined through two tests:

1. **Percentage of Full-Time Employees Enrolled**: Are at least 25% of "full-time" employees enrolled in the employer-sponsored health plan?
2. **Premium Contribution Standard**: Does the employer offer to pay at least 33% of the cost of individual coverage, under any group health plan offered by the employer, for its "full-time" employees who have been employed for at least 90 days?

Effective January 1, 2009, as reflected in revised regulations that were finalized in September 2008, the rules for determining compliance have changed:

Employers of 50 or fewer FTE employees will continue to comply by passing just one of the two tests described above.

Employers of 51 or more FTE employees will automatically comply if at least 75% of their "full-time" employees are enrolled in their employer-sponsored group health plan(s).

Employers of 51 or more FTE employees with less than 75% of "full-time" employees enrolled must pass both tests in order to avoid paying the financial penalty

The calculations in each test are based on all "full-time employees" who are employed at Massachusetts locations, regardless of where they reside. "Full-time" is defined in the regulations as an employee who works, the majority of the time, 35 hours per week or the number of hours required for "full-time" benefits, whichever is less. It is very important that employers understand that the regulatory definitions must be applied for purposes of compliance – not the employer's own definition.

Calculation of Percentage of Full-Time Employees Enrolled test

The percentage of enrolled employees is calculated by dividing the total number of *enrolled* full-time employees by the total number of *all* full-time employees.

Compliance Filing Process

Compliance with the fair share contribution obligation is determined through an online filing administered by the MA Division of Unemployment Assistance (DUA). Employers of eleven (11) or more FTE employees are required to complete the filings whether or not they receive a filing notice from the DUA, i.e., it is the employer's responsibility to be aware of and to fulfill its filing obligation.

A provision contained in the Supplemental Budget bill passed by the state legislature in July of 2008, requires that fair share compliance be determined on a quarterly basis rather than annually. Through the regulatory process, the quarterly filing requirement was modified as reflected below:

For the quarter ending December 31, 2008, all covered employers were required to file and passing just one of the two tests resulted in compliance. The data submitted for the two tests then determined the employer's filing status for the remainder of 2009:

Those who very easily passed are not required to file again for one year – for the quarter that ends December 31, 2009 – and were so notified at the conclusion of the filing process. As part of their next filing they will be asked if they remained in compliance for the quarters ending March, June and September 2009, for which the new compliance rules described above will apply. If not, they will be required to enter data for those 3 quarters and will be assessed the applicable penalty plus 12% interest.

Employers may voluntarily continue to file quarterly even if not required to do so.

Those who failed to comply in the quarter that ended December 31, 2008 as well as those who are deemed, by the DUA in its sole discretion, to be near-fails or likely future-fails, were notified that they must continue to file on a quarterly basis.

For additional details on the compliance filing process, see the next Fact Sheet located in this Section.

Determination of Annual Fair Share Employer Contribution

The fair share assessment will be the lower of $295 per FTE employee per year and the sum of the fair share employer contribution and the per-employee cost of unreimbursed physician care. Full details of this calculation are in the regulations. To date, the full $295 has been used as the penalty amount.

Fair Share Contribution – Compliance Information

There is nothing in the health care reform law that requires an employer to provide health insurance to its employees. There is a financial implication, however, for employers of 11 or more that do not offer insurance to full-time employees or do not make a "fair and reasonable" contribution toward the cost of the coverage they do offer. Employers that do not comply with this provision of the law will be subject to a "fair share assessment" of up to $295 per full-time equivalent (FTE) employee per year.

Employers of 11 or more full-time equivalent employees must comply. (See the Fact Sheet for "Determination of Coverage Under the Law" in Section 2 of this Guide.) The Department of Unemployment Assistance (DUA) is responsible for enforcing the fair share contribution (FSC) requirement, and for collecting any assessments.

Compliance Changed from Annual to Quarterly Basis

In July 2008, the legislature changed fair share compliance from an annual to a quarterly determination in order to generate significantly more revenue from penalties and to collect that revenue more quickly. Quarters and filing periods are as follows:

Determination Period	Filing/Payment Period
October 1 – December 31	January 1 – February 15
January 1 – March 31	April 1 – May 15
April 1 – June 30	July 1 – August 15
July 1 – September 30	October 1 – November 15

In December 2008 the DUA issued a notice of the statutory and regulatory changes related to fair share compliance. Some of the important information and clarifications contained in this document:

- Liability under the FSC obligation is now based upon per-quarter compliance rather than on the year as a whole. This means it is possible for an employer to be in compliance one or more quarters and to be liable for a non-compliance penalty in other quarters.
- Quarterly filing periods will run for 45 days following the end of each quarter and employers must both file, and pay in full, any penalty owed within that 45-day period – no more installment payments.
- For the quarter ending December 31, 2008 only, there was no change to the compliance requirements, i.e., for all employers, passing just one of the two compliance tests resulted incompliance.
- FSC penalty amounts for 2009 will be $73.75 per FTE employee for each non-compliant quarter. (A corresponding 25 percent of the $295 maximum annual penalty permitted by the statute.)
- DUA will continue to notify employers, but failure to receive a notice from DUA does not relieve employers with 11 or more FTE employees (5,500 or more quarterly payroll hours) from their responsibility to file.
- Detailed filing instructions are no longer mailed out to employers, but are provided electronically through the DUA online compliance filing system.

Fortunately, relatively few employers will be required to file for all four quarters each year. Determined lobbying by AIM resulted in regulatory modifications to the statutory quarterly filing requirement. These changes are beneficial to many thousands of Massachusetts employers, but to the state as well. Some key points:

- All covered employers were required to complete the filing for the quarter of October through December of 2008.
- Only employers that owed a penalty for that filing, plus those that were "near-fails" or that were determined to be at risk of owing a penalty in subsequent quarters, will be required to continue filing on a quarterly basis.
- Employers that easily complied for the quarter ending Dec. 31, 2008 will be required to file again in one year – for the quarter ending Dec. 31, 2009 – and will be asked at that time to certify whether they remained in compliance for the quarters ending in March, June and September of 2009 according to the new testing criteria effective for those quarters. If the answer is "no" the employer will be required to complete filings for those 2009 quarters and will be liable for interest, as required by law, in addition to the applicable quarterly per-FTE employee penalty.
- DUA retains sole discretion in determining which employers must file quarterly and will use all data available to them in making these decisions. For example, they will consider an employer's historic workforce fluctuations as well as likelihood of non-compliance under the new fair share testing criteria.
- DUA estimates that only 1,200 of the 34,000 employers covered by the law will be required to file quarterly.

This dramatic reduction in the administrative burden placed on employers, and on DUA, is a significant achievement any time, but particularly in light of current economic challenges.

While the above information reflects 2009 requirements, it is anticipated that employers with ongoing quarter-to-quarter compliance will continue to formally file for one quarter of the year and to certify their compliance for the remaining quarters.

New Fair Share Compliance Testing Criteria Effective January 1, 2009

Effective with the quarter of January 1 through March 31, 2009, new rules determine whether or not many employers are making a "fair and reasonable" contribution toward the cost of health insurance for their employees. Some key points from Division of Health Care Finance and Policy regulations finalized on September 30, 2008:

- Terminology has changed – while the two fair share compliance tests remain, they are no longer referred to as the "primary" and "secondary" tests. The new tests are:
    1. "Percentage of Full-Time Employees Enrolled" (formerly the Primary Test) – still requires enrollment of at least 25% of "full-time" employees in the employer's own group health plan. (Reminder: the regulatory definition of "full-time" must be used for both tests.)
    2. "Premium Contribution Standard" (formerly the Secondary Test) – still requires the offer to contribute at least 33% toward the cost of an individual policy for all "full-time" employees "no more than 90 days following the date of hire."
- For the quarter ended December 31, 2008, employers, regardless of size, were in compliance if they passed just one of the two tests – i.e., the old rules continued to apply.

- Effective January 1, 2009 – the quarter ending March 31, 2009 – the rules changed, but only for employers of more than 50 FTE employees:
  - For employers of 50 or fewer FTE employees there is still no change – passing just one of the tests will continue to result in compliance.
  - Employers of more than 50 FTE employees will automatically comply if 75% of "full-time" employees are enrolled in the employer's own group health plan(s).
  - Employers of more than 50 FTE employees with "full-time" take-up rates below 75% will now be required to pass both tests in order to avoid paying a penalty.

The special considerations for small employers and for larger employers with very high take-up rates are the direct result of proactive lobbying by AIM and other prominent business groups. Draft rules simply required all employers to pass both compliance tests.

Compliance Test Guidance

Percentage of Full-time Employees Enrolled: Were at least 25% of full-time employees enrolled in the employer's group health plan(s) during the quarterly determination period? This is the ratio of total number of "full-time" enrolled employees to total number of all "full-time" employees taken as a snapshot on the last day of each quarter (December 31, March 31, June 30, and September 30). If the average number of enrolled is equal to at least 25% of the total number of full-time, the employer passes the percentage of full-time employees enrolled test. Calculation:

$$\frac{\text{Total number of all } \textbf{\textit{enrolled}} \text{ "full-time" employees as of last day of quarter}}{\text{Total number of } \textbf{all} \text{ "full-time" employees as of last day of quarter}} = \boxed{} \textbf{ Percentage}$$

For employers with 50 or fewer full-time equivalent employees:

- A resulting number of 25 or more = passed percentage of full-time employees enrolled test and not subject to the fair share assessment.
- A number of less than 25 = must pass premium contribution standard test in order to avoid the fair share assessment.

For employers with more than 50 full-time equivalent employees:

- A resulting number of 75 or more = passed percentage of full-time employees enrolled test and not subject to fair share assessment.
- A number between 25 and 75 = must also pass the premium contribution standard test in order to avoid the fair share assessment.
- A number less than 25 = failure to comply with the fair share contribution requirement and subject to the fair share assessment.

Important Notes for Calculation:

- The numerator does not include employees who were covered under any other plan, such as a spouse's or parent's plan, MassHealth, Medicare, etc.
- The denominator includes all full-time employees – those enrolled in the employer's group health plan(s) and those not enrolled in the group health plan(s), including those who have not yet completed their eligibility waiting period.
- Both the numerator and denominator only include employees who were on payroll the last day of the quarter and who had been on payroll for at least one month.
- Employers must count as "full-time" any employee who works full-time a "majority" of his/her time during the quarter, regardless of how s/he is classified by the employer. Employees who legitimately meet the regulatory definitions of "temporary" or "seasonal" need not be counted regardless of the number of hours they work.
- Employers that contribute to a multi-employer health plan on behalf of full-time employees, pursuant to collective bargaining agreement(s), may count those employees as being enrolled in the employer-sponsored health plan.
- Employers that provide services to the federal government, and are required to contribute toward the benefits of full-time employees as prescribed in those government contracts, may count those full-time employees as being enrolled in the employer-sponsored health plan.

Premium Contribution Standard Test: Did the employer offer to contribute at least 33% of the cost of an individual policy for all "full-time" employees, as defined in the regulations, no more than 90 days following hire?

1. What percentage does your company contribute toward the premium cost for individual coverage for all full-time employees? _____%
2. If you contribute a flat dollar amount toward the cost of individual coverage:
   - What is the individual premium cost? _____
   - What is the dollar contribution for individual coverage? _____
   - Divide the dollar contribution amount by the premium cost = _____%
3. During the determination period, what was the waiting period for all full-time employees to enroll in the health plan(s) offered by your company? _____ Days

If the percentage in either #1 or #2 above is equal to or greater than 33% the employer passes the premium contribution standard test **IF** the waiting period for coverage is no longer than 90 days.

An employer that has a group health insurance waiting period longer than 90 days will automatically fail the premium contribution standard test.

Important Notes:

In order to conduct the tests, it is very important to understand certain definitions. It is also very important to remember that, for purposes of determining compliance with any law, it does not matter how an employer defines "full-time," "part-time," "temporary," or "seasonal" employees. What matters is how they are defined under the various laws and regulations. The following definitions and rules apply to provisions of the health care reform law:

- **Full-time Employee –** Defined as an employee who works the lesser of 35 hours per week or the number of hours required to qualify for "full-time" benefits and who has been employed at least one month.
- **Temporary Employee –** Defined as a W-2 employee whose employment is explicitly temporary and who works fewer than 12 consecutive weeks during the year.
- **Seasonal Employee –** Defined as an employee who holds a "seasonal" position, as officially determined by the Department of Unemployment Assistance, whose employment is limited to the beginning and end of the employer's season, and who is employed for no more than 16 weeks of the year. Very few employees meet this definition.
- Full-time employees who are not residents of Massachusetts, but who work at/for a Massachusetts location must be included when conducting the two tests.
- "Temporary" and "seasonal" employees meeting the above definitions are not included for purposes of either test, regardless of the number of hours they work.
- A worker who is employed through a "temp agency" is not considered an employee of the client company.
- Independent contractors are not considered to be employees. Massachusetts employers must take great care, however, in classifying someone as an independent contractor. It is extremely difficult to meet the state definition and to legally not classify an individual as employee.

114.5 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.5 CMR 16.00: EMPLOYER FAIR SHARE CONTRIBUTION

16.01 General Provisions

(1) Scope and Purpose. 114.5 CMR 16.00 governs the determination of whether an Employer makes a Fair and Reasonable Premium Contribution to the health insurance cost of its Employees. Employers that make a Fair and Reasonable Premium Contribution are exempt from the Employer Fair Share Contribution under M.G.L. c. 149, § 188. 114.5 CMR 16.00 also governs the determination of the annual Fair Share Contribution Amount. The Fair Share Contribution is collected by the Division of Unemployment Assistance from Employers of eleven or more full time equivalent employees in accordance with 430 CMR 15.00.

(2) Authority: 114.5 CMR 16.00 is adopted pursuant to M.G.L. c. 149, § 188.

(3) Effective Date. 114.5 CMR 16.00 is effective on October 1, 2008.

16.02 Definitions

Meaning of Terms: As used in 114.5 CMR 16.00, unless the context otherwise requires, terms have the following meanings:

Client Company. 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.

Commissioner. The Commissioner of the Division of Health Care Finance and Policy.

Contributing Employer. An Employer that offers a Group Health Plan to which the Employer makes a fair and reasonable premium contribution as defined in 114.5 CMR 16.03.

Division. The Division of Health Care Finance and Policy established under M.G.L. c. 118G or its designated agent.

Employee. An individual employed for at least one month during the twelve month period ending with the last day of the applicable reporting period by an Employer at a Massachusetts location subject to M.G.L. c. 149, § 188.

Employee Leasing Company. 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. Notwithstanding any arrangement between a client company and an Employee Leasing Company, the Client Company is the Employer for purposes of M.G.L.c. 149, s.188 and 114.5 CMR 16.00.

Employer. An employing unit as defined in section 1 of M.G.L. chapter 151A or chapter 152.

Enrolled Employee. An employee who has accepted and is enrolled in the employer's sponsored Group Health Plan.

Full-Time Employee. A Full-Time Employee is an Employee that works the lower of (1) 35 or more hours per week or (2) the number of weekly payroll hours to be eligible for the Employer's Full-Time Health Plan Benefits.

Full-Time Health Plan Benefits. The level of employer contribution to the Group Health Plan that is equivalent to the contribution offered to Full-Time Employees.

Group Health Plan. 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 to which the employer contributed.

Independent Contractor**.** An individual that provides services not deemed to be employment under M.G.L. c. 151A, § 2 or M.G.L. c. 152 in the case of services for employing units not subject to M.G.L. c.151A.

Medical Care. Medical services for the diagnosis, cure, treatment, or prevention of disease, as defined in Internal Revenue Code Section 213(d)(1)(A) and (B).

Multi-Employer Group Health Plan. A Multi-Employer Health Plan is a Group Health Plan to which more than one employer is required to contribute, and which is maintained pursuant to one or more collective bargaining agreements between employee organization(s) and the employers.

Seasonal Employee. An individual hired to perform services for wages by a seasonal employer under M.G.L. c. 151A during the seasonal period in the employer's seasonal operations for a specific temporary seasonal period; that has been notified by the Division of Unemployment Assistance that the individual is performing services in seasonal employment for a seasonal employer; whose employment is limited to the beginning and ending dates of the employer's seasonal period; and whose employment does not exceed sixteen weeks.

16.03 Determination of Fair and Reasonable Premium Contribution.

(1) General. An Employer that employs eleven or more full-time equivalent Employees in the Commonwealth as determined under 114.5 CMR 16.03 (2) and is not a Contributing Employer as determined under 114.5 CMR 16.03 (3) shall pay a per Employee contribution in accordance with 430 CMR 15.00.

(2) Number of Employees. An Employer has eleven or more full-time equivalent Employees if the sum of total payroll hours for all Employees for a calendar quarter, divided by 500, is greater than or equal to eleven. In calculating total payroll hours:

(a) For each Employee with more than 500 payroll hours, the Employer shall include 500 payroll hours.

(b) Payroll hours include all hours for which an Employer paid wages to an Employee including, but not limited to, regular, vacation, sick, Federal Medical Leave of Absence, short term disability, long term disability, overtime and holiday payroll hours.

(c) An Employer that is determined to be a successor under M.G.L. c. 151A shall include the payroll hours of the predecessor's Employees during the applicable period.

(d) Payroll hours include hours for which an Employer paid wages to a temporary employee as defined in 430 CMR 4.04(8)(a) provided that the individual has worked for the Employer for at least 150 payroll hours during the twelve month period ending with the last day of the applicable reporting period.

(3) Contributing Employer Determination.

(a) General. A Contributing Employer that makes a Fair and Reasonable Premium Contribution in accordance with 114.5 CMR 16.03(3) is not liable for the Fair Share Contribution. For purposes of 114.5 16.03(3) (b) and (c):

1. An Employer shall include all Full-Time Employees employed at Massachusetts locations, whether or not they are Massachusetts residents. An Employee that works both full-time and part-time during a calendar quarter is a Full-Time Employee if he or she worked "Full-Time" a majority of his or her time during the quarter.

2. An Employer shall exclude Seasonal Employees and temporary employees. A temporary employee is an employee that works for an Employer on either a full or part-time basis whose employment is explicitly temporary in nature and does not exceed 12 consecutive weeks during the twelve month period ending on the last day of the reporting quarter.

(b) Percentage of Full-Time Employees Enrolled.

1. Each Employer shall calculate the percentage of Full-Time Employees enrolled in its Group Health Plan for each quarter as follows:

a. The Employer shall identify and record the number of Full-Time Employees enrolled in the Group Health Plan on the last day of the calendar quarter.

b. The Employer shall identify and record the number of Full-Time Employees on the Employer's payroll on the last day of the calendar quarter.

c. The Employer shall calculate the percentage of Full-Time Employees enrolled for the quarter by dividing the number of Full-Time Employees enrolled in the Group Health Plan for the quarter by the number of Full-Time Employees for the quarter.

2. An Employer may include the following Employees in the calculation of Employees enrolled in the Group Health Plan:

a. Multi-Employer Health Plans. If the Employer makes premium contribution payments to a Multi-Employer Health

Plan on behalf of an Employee, the Employer may include that Employee in the calculation of the percentage of Full-Time Employees enrolled in its group health plan.

b. Federal Contracts. An Employer that makes an employee benefit contribution for a Full-Time Employee in accordance with federal requirements, the Employer may include that employee in the number of employees enrolled in the health plan.

c. Prevailing Wage. An Employer that makes an employee benefit contribution to a health and welfare plan for a Full-Time Employee in accordance with M.G.L. c. 149, § 27 may include that Employee in the number of Employees enrolled in the health plan.

d. Exempt Employees. An Employer may exclude a Full-Time Employee from the denominator of the percentage of Full-Time Employees enrolled if the employee claims exemption from the requirements of M.G.L. c. 111M, § 2 because of sincerely held religious beliefs and has filed an affidavit in accordance with M.G.L. c. 111M, § 3. The Employer must maintain documentation to verify that the employee has claimed such an exemption.

(c) Premium Contribution Standard. To meet the premium contribution standard, an Employer must make a premium contribution of at least 33% of the cost of an employer sponsored Group Health Plan offered to all of its Full-Time Employees no more than ninety days after the date of hire Said Group Health Plan must be in effect and available to those Full-Time Employees for the entire quarter, or, where the Employer or its predecessor was not in operation during the entire quarter, for that portion of such quarter that the Employer or its predecessor was in operation.

1. An Employer that contributes to an employer sponsored Group Health Plan and also contributes to a Multi-Employer Group Health Plan, including a Taft-Hartley Plan, or makes employee benefit contributions pursuant to federal contract requirements or M.G.L. c. 149, § 27, shall determine its compliance with the premium contribution standard based only on its employees enrolled in its Group Health Plan.

2. If an Employer makes different percentage contributions for different employee groups, compliance with the premium contribution standard is based on the lowest premium percentage contribution.

(d) Contributing Employer Determination. An Employer is determined to be a Contributing Employer based on the percentage of Full-Time Employees enrolled in its Group Health Plan under 114.5 CMR 16.03(3)(b); its compliance with the premium contribution standard under 114.5 CMR 16.03(3)(c); and the number of full-time equivalent employees calculated under 114.5 CMR 16.03(2).

1. For the period from October 1, 2008 to December 31, 2008, an Employer is a Contributing Employer if

a. its percentage of Full-Time Employees enrolled is at least 25%, or

b. it meets the premium contribution standard.

2. Effective January 1, 2009, an Employer is a Contributing Employer if:

a. for an Employer with more than 50 full-time equivalent employees:

i. its percentage of Full-Time Employees enrolled is at least 25% and it meets the premium contribution standard; or

ii. its percentage of Full-Time Employees enrolled is at least 75%.

b. for an Employer with 50 or fewer full-time equivalent employees, if:

i. its percentage of Full-Time Employees enrolled is at least 25%, or

ii. it meets the Premium Contribution standard.

16.04 Determination of Annual Fair Share Employer Contribution

(1) Determination of Contribution Amount. The Annual Fair Share Employer Contribution Rate is the lower of (1) $295 per employee or (2) the sum of the Fair Share Employer Contribution and the Per Employee Cost of Unreimbursed Physician Care as calculated in accordance with 114.5 CMR 16.04. The Fair Share Employer Contribution Rate shall be determined annually by the Division in consultation with the Director of the Department of Workforce Development using the best available data. The Annual Fair Share Employer Contribution Rate shall be adjusted to reflect a quarterly rate based on 25 percent of the annual fair share contribution rate applicable to that quarterly period.

(2) Fair Share Employer Contribution Rate. The Division will determine the Annual Fair Share Employer Contribution Rate as follows:

(a) Determine the per user share of Private Sector Liability by dividing total Private Sector Liability for the Fiscal Year by the total number of users of the Health Safety Net in the most recent fiscal year.

(b) Determine the number of employee users that received services funded by the Health Safety Net;

(c) Multiply the total number of employee Health Safety Net users by the percentage of employers that are non-Contributing Employers.

(d) Determine the total cost of liability associated with employees of non-Contributing Employers by multiplying the number of users that are employees of non-Contributing Employers by the Per User Share of Private Sector Liability.

(e) Divide the total liability for employees of non-Contributing Employers by the total number of employees of non-Contributing Employers as determined by the Division.

(f) Adjust by medical inflation as determined by the Division.

(3) Per Employee Cost of Uncompensated Physician Care

(a) The Division will determine the total amount of uncompensated health care services provided by physicians to non-elderly, uninsured residents of the Commonwealth. The Division will use the best available data, including survey data or other data source.

(b) The Division will divide this amount by the number of employees of contributing Employers to determine the Per Employee Cost of Uncompensated Physician Care.

(4) The Sum of the Fair Share Employer Contribution and the Per Employee Cost of Uncompensated Physician Care is the Annual Fair Share Contribution Rate.

16.05 Other Provisions.

(1) General. Each Employer shall file or make available information which is required or which the Division deems reasonably necessary for calculating the Employer Fair Share Contribution.

(2) Severability. The provisions of 114.5 CMR 16.00 are severable. If any provision or the application of any provision is held to be invalid or unconstitutional, such invalidity shall not be construed to affect the validity or constitutionality of any remaining provisions of 114.5 CMR 16.00 or the application of such provisions.

(3) Administrative Bulletins. The Division may issue administrative bulletins to clarify policies, update administrative requirements and specify information and documentation necessary to implement 114.5 CMR 16.00.

REGULATORY AUTHORITY

114.5 CMR 16.00 M.G.L. c. 118G.

Regulations issued by the Division of Unemployment Assistance – Fair Share Compliance Filings

430 CMR 15.00: FAIR SHARE EMPLOYER CONTRIBUTION

430 CMR 15.00: FAIR SHARE EMPLOYER CONTRIBUTION

15.01: Purpose

The purpose of 430 CMR 15.01 through 15.11 is to interpret the standards for determining when an employer is liable for payment of the fair share employer contribution under M.G.L. c. 149, §188; to establish procedures for filing of required reports, payment of the fair share employer contributions and implementing of penalties against employers who fail to file the required reports or make the required payments; and to otherwise define how the Division of Unemployment Assistance will administer M.G.L. c. 149, §188 with regard to the fair share employer contributions.

15.02: General Provisions

(1) Scope and Applicability. 430 CMR 15.01 through 15.11 applies to all employers as defined in M.G.L. c. 149, §188(a). 430 CMR 15.00 governs the collection and payment of the fair share employer contributions. The provisions of 114.5 CMR 16.00 govern the determination of whether an employer makes a fair and reasonable premium contribution to the health insurance cost of its employees.

(2) Effective Date. 430 CMR 15.00 is effective on October 1, 2008. For the Base Period ending September 30, 2007, the provisions of 430 CMR 15.00 as then in effect shall apply. For the Base Period ending September 30, 2008, the provisions of 430 CMR 15.00 as then in effect shall apply, except that, the August 15, 2009 quarterly payment specified in 430 CMR 15.07(3) is due June 23, 2009.

15.03 Definitions

As used in 430 CMR 15.00, the following words and phrases shall have the following meanings unless the context otherwise requires:

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

Contributing Employer, an employer that offers a group health plan during the entire quarterly period or such portion of the quarter that the employer was subject to M.G.L. c. 151A or M.G.L. c. 152 to which the employer makes a fair and reasonable premium contribution as defined in 114.5 CMR 16.03 .

Director, the Director of the Division of Unemployment Assistance or his designee.

Division, the Division of Unemployment Assistance.

Employee, an individual, whether or not a resident of Massachusetts, who is employed for at least 150 payroll hours during the twelve month period ending with the last day of the applicable quarterly period by an employer at a Massachusetts location subject to M.G.L. c. 149, § 188.

Employee Leasing Company, an employing unit that contracts with a client company to supply workers to perform services for the client company; provided, that the term "employee leasing company" does not include private employment agencies that provide workers to employers on a temporary basis or entities such as driver-leasing companies which lease employees to an employing unit to perform a specific service. Notwithstanding any arrangement between a Client Company and an Employee Leasing Company, the Client Company is the employer for purposes of M.G.L. c. 149, § 188 and 430 CMR 15.00.

Employer, an employing unit as defined in M.G.L. c. 151A, §1 or M.G. L. c. 152.

Fair Share Employer Contribution, the contribution required by M.G.L. c. 149, §188(b).

Independent Contractor, an individual who provides services not deemed to be employment under M.G.L. c. 151A, §2 or M.G. L. c. 152.

Payroll Hours, includes all hours for which an employer paid wages as defined in M.G.L. c. 151A, §1(s) to an employee.

Quarter, any one of the following periods in any year; - January first to March thirty-first, inclusive; April first to June thirtieth, inclusive; July first to September thirtieth, inclusive; October first to December thirty-first, inclusive.

15.04: Subjectivity

Any employer subject to the provisions of M.G.L. c. 151A or M.G. L. c. 152 is subject to the provisions of 430 CMR 15.00 whether or not the employer is required to pay the fair share employer contribution.

15.05: Liability for Fair Share Employer Contributions Under M.G.L. c. 149, §188

(1) Any employer that:

- employs 11 or more full-time equivalent employees in the commonwealth; and
- is not a contributing employer

shall pay a per-employee contribution at a time and in a manner prescribed by the Director.

(2) An employer has 11 or more full-time equivalent employees if the sum of total payroll hours for all employees employed for such employer during the applicable quarter divided by 500 is greater than or equal to eleven. In calculating total payroll hours, the employer shall include no more than 500 payroll hours for any employee.

(3) Applicable Base Period

(a) Except as provided in subsections (b) and (c), the applicable base period shall be the 12 consecutive month period beginning each October 1st and ending September 30th of the following year.

(b) Where the employer becomes subject to the provisions of M.G.L. c. 151A or M.G.L. c. 152 during the base period, the applicable base period shall be the period beginning with the date of subjectivity and ending the last day of the applicable quarterly period. The provisions of this paragraph shall not apply to an employer who has been determined to be a successor under M.G.L. c. 151A or M.G. L. c. 152.

(c) Beginning October 1, 2008, the applicable base period shall be the three consecutive month period beginning with the first day of the calendar quarter and ending with the last day of such calendar quarter.

(4) In making the calculation required by 430 CMR 15.05(2), an employer who is determined to be a successor under M.G.L. c. 151A or M.G. L. c. 152 shall include the payroll hours of the predecessor's employees during the applicable quarterly period.

15.06: Contributions Due Under M.G.L. c. 149, §188

(1) Employers' annual contribution rate as calculated under M.G.L. c. 149, §188 is the sum of the fair share employer contribution and the per employee cost of unreimbursed physician care as calculated in accordance with 114.5 CMR 16.04 or $295.00 per employee, whichever is the lesser amount.

(2) The Director shall assess each employer liable for a fair share employer contribution in a quarter, an amount based on 25 percent of the annual fair share employer contribution rate applicable to that quarterly period. The total quarterly fair share employer contribution liability is the product of the quarterly fair share employer contribution rate as determined by the first sentence of this subsection and the total number of employees employed by the employer during that quarter.

(3) Employers shall pro-rate the contribution rate specified in 430 CMR 15.06 (2) by a fraction which shall not exceed one, the numerator of which is the number of hours worked in a quarter by all of the employer's employees and the denominator of which is the product of the number of employees employed by an employer during the applicable quarter multiplied by 500 hours.

(4) The fair share employer contribution rate shall be determined annually by the Commissioner of the Division of Health Care Finance and Policy in consultation with the Director of the Department of Workforce Development based on the best available data.

(5) For base periods beginning on or after October 1, 2008, employers liable for the fair share employer contributions must make such payments in full in accordance with the schedule provided in 430 CMR 15.07(3).

15.07: Reporting and Payment Requirements

(1) Employers shall file with the Director in the form, manner, time and frequency as determined by said Director such reports necessary to determine their liability for the fair share employer contribution.

(2) Employers liable for the fair share employer contribution shall file the required reports using the form and means of electronic transmittal as prescribed by the Director and shall remit the required payment through an electronic funds transfer in a form prescribed by the Director.

(3) For base periods beginning on or after October 1, 2008, employers liable for the fair share employer contributions must make payments as specified below:

First Quarter Payment	February 15th
Second Quarter Payment	May 15th
Third Quarter Payment	August 15th
Fourth Quarter Payment	November 15th

(4) The failure of the Division of Unemployment Assistance to notify employers of their reporting and payment requirements under M.G.L. c. 149, §188 and 430 CMR 15.00 does not absolve employers from such requirements.

(5) Any payments associated with an employer's fair share employer contributions may not be combined with payments due under M.G.L. c. 151A.

15.08: Penalties

(1) If an employer fails to pay any portion of the fair share employer contribution due under M.G.L. c. 149, §188 and 430 CMR 15.00, the overdue amount shall be assessed a penalty charge at a rate of 12% *per annum* from the date due until the date paid.

(2) The Director may refer any matter to the Office of the Attorney General where there has been:

(a) attempts to evade or defeat any contribution or penalty due under M.G.L. c. 149, §188 or 430 CMR 15.00; or

(b) false statement or misrepresentation to avoid or reduce any financial liabilities under M.G.L. c. 149, §188 or 430 CMR 15.00.

15.09: Refunds

If an employer pays its fair share employer contribution in excess of the amount due, the employer shall be eligible for a refund from the Commonwealth Care Trust Fund established by M.G.L.c.29, § 2OOO or credit of the excess amount on its fair share employer contribution liability at the discretion of the Director. Applications for refunds or credit must be filed within three years of the date of payment of the contributions required by M.G.L. c. 149, §188.

15.10: Appeal

(1) An employer aggrieved by a determination of the Director with respect to its liability for the fair share employer contribution or with respect to the amount it must pay may appeal such determination in accordance with the provisions set forth in M.G.L. c. 151A, §39(b) and in the form and manner as specified by the Director.

(2) The provisions of M.G.L. c. 151A, §39(b) and the Standard Adjudicatory Rules of Practice and Procedure found in 801 CMR 1.02: *Informal/Fair Hearing Rules* and 1.03: *Miscellaneous Provisions Applicable to All Adjudicatory Proceedings* shall apply to hearings conducted with respect to appeals filed under 430 CMR 15.10(1)

(3) A party aggrieved by any decision issued pursuant to a hearing conducted under 430 CMR 15.10(2) may file a petition for judicial review in Superior Court pursuant to M.G.L. c. 30A, §14.

15.11: Other Provisions

(1) References in these regulations to M.G.L. c. 152 shall apply only to those employers not subject to M.G.L. c. 151A.

(2) General. Each employer shall file with or make available to the Director information which is required or which the Director deems necessary for calculating and collecting the fair share employer contributions.

(3) Administrative Notices. The Director may issue administrative notices to clarify policies, update administrative requirements and specify information and documentation necessary to implement these regulations.

(4) Severability. If any provision or the application of any provision is held to be invalid or unconstitutional, such invalidity shall not be construed to affect the validity or constitutionality or any remaining provision of 430 CMR 15.00

Section 7
Health Insurance Responsibility Disclosure (HIRD)

Fact Sheet: Health Insurance Responsibility Disclosure (HIRD)

Final Regulations – Health Insurance Responsibility Disclosure

Health Insurance Responsibility Disclosure – Employee Form (English)

Health Insurance Responsibility Disclosure – Employee Form (Spanish)

Health Insurance Responsibility Disclosure – Employee Form (Portuguese)

Associated Industries of Massachusetts

Fact Sheet

The Massachusetts Health Care Reform Law

Health Insurance Responsibility Disclosure (HIRD)

Status of Regulations:	Final Regulations
Administrative Agency:	Division of Health Care Finance and Policy (DHCFP)
Effective Date:	April 1, 2009

General Information

The Health Insurance Responsibility and Disclosure obligation requires submission of certain employee and/or employer information and also establishes recordkeeping requirements.

Employer HIRD Report

Employers of 11 or more full-time-equivalent (FTE) employees must submit HIRD information to verify that they have a Section 125 plan, and to provide information about the employer and its group health insurance practices. This is done as part of the online fair share compliance filing process which is administered by the Division of Unemployment Assistance.

See regulations included in this Section for details on reportable information.

Employee HIRD Form

Each employee of a Massachusetts employer with 11 or more FTE employees who declines to enroll in employer-sponsored insurance and/or declines to enroll in the employer's Section 125 cafeteria plan is required to complete and sign an employee HIRD Form. The employee answers questions related to what was offered to the employee, the employee's decision to waive participation, and whether or not the employee has health insurance coverage through another source. The employee's signature acknowledges that the information is provided under penalties of perjury, that he/she is aware of the potential consequences of being uninsured.

The employer must complete the first section of the form which collects information about the employer, the plans offered to the employee, plus the monthly amount of the employee contribution required for participation in the lowest-cost plan available to the employee.

The signed HIRD form must be completed within 30 days of the end of each eligibility enrollment period – initial enrollment, annual open enrollment, special election period under HIPAA, etc. A form must be signed by each employee who waives, each time s/he waives participation.

The employee must be given a copy of the signed form for potential use when filing the Massachusetts income tax return and must be provided additional copies upon request.

An employer's own form may be substituted for the employee HIRD Form provided the employer form collects at least the information included on the DHCFP model form. Electronic forms and signatures are acceptable.

See the regulations for a detailed list of the information collected on the Employee HIRD Form. Copies of the 2009 Employee HIRD Form in English, Spanish and Portuguese are also provided.

Recordkeeping Requirements

The employer must retain signed Employee HIRD Forms for a period of 3 years.

AIM Recommendation – To simplify HIRD administration, keep signed HIRD forms in a separate confidential file or binder, grouped by the year of signature and alphabetical within each year. This makes it very easy to locate a form when needed for any reason. Destroy/delete "expired" forms once per year, i.e., at the end of 2010, destroy all forms signed in 2007. At the end of 2011, destroy all forms signed in 2008 and so forth.

Since these forms contain "personal information" as defined by Massachusetts law, be sure the records are maintained and ultimately destroyed or deleted in accordance with regulations related to Chapter 93H. As this Guide is being revised, stringent data security regulations are set to become effective on January 1, 2010.

114.5 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.5 CMR 18.00 HEALTH INSURANCE RESPONSIBILITY DISCLOSURE

18.01 General Provisions

(1) Scope and Purpose. 114.5 CMR 18.00 governs the filing requirements for the Health Insurance Responsibility Disclosure Form. Each Massachusetts Employer with eleven or more Full Time Equivalent Employees is required to file information about its compliance with the M.G.L. c. 151F requirement to adopt and maintain a Section 125 Cafeteria Plan. Each Employee of a Massachusetts Employer with eleven or more Full Time Equivalent Employees that declines the Employer's offer of health insurance or declines to use the Employer's Section 125 Cafeteria Plan to purchase other health insurance is required to sign an Employee HIRD form.

(2) Authority: 114.5 CMR 18.00 is adopted pursuant to M.G.L. c. 118G, § 6C.

(3) Effective Date. 114.5 CMR 18.00 is effective on April 1, 2009.

18.02 Definitions

Meaning of Terms: As used in 114.5 CMR 18.00, unless the context otherwise requires, terms have the following meanings:

151F Employer. An Employer subject to the M.G.L. c. 151F requirement to adopt and maintain a Section 125 Cafeteria Plan in accordance with the regulations of the Connector at 956 CMR 4.00 et seq.

Client Company. A person, association, partnership, corporation or other entity that uses workers provided by an Employee Leasing Company pursuant to a contract.

Connector. The Commonwealth Health Insurance Connector established under M.G.L. c. 176Q.

Division. The Division of Health Care Finance and Policy established under M.G.L. c. 118G or its designated agent.

Employee. An individual employed by any Employer at a Massachusetts location, whether or not the individual is a Massachusetts resident, for at least one month.

Employee Leasing Company. 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.

Employer. An Employing Unit subject to M.G.L. c. 151A, and the commonwealth, its instrumentalities, political subdivisions, an instrumentality of a political subdivision, including municipal hospitals, municipal electric companies, municipal water companies, regional school districts and any other instrumentalities as are financially independent and are created by statute.

Employing Unit. Any individual or type of organization including any partnership, firm, association, trust, trustee, estate, joint stock company, insurance company, corporation, whether domestic or foreign, or his or its legal representative, or the assignee, receiver, trustee in bankruptcy, trustee or successor of any of the foregoing or the legal representative of a deceased person who or which has or had one or more individuals performing services for him or it within the Commonwealth of Massachusetts. An entity is an Employing Unit whether or not the services performed are deemed employment under c. 151A.

Independent Contractor. An individual that provides services not deemed to be employment under M.G.L. c. 151A, § 2 because:

(a) such individual has been and will continue to be free from control and direction in connection with the performance of such services, both under his contract for the performance of service and in fact;
(b) such service is performed either outside the usual course of business for which the service is performed or is performed outside of all the places of business of the enterprise for which the service is performed; and
(c) such individual is customarily engaged in an independently established trade, occupation, profession or business of the same nature as that involved in the service performed.

Section 125 Cafeteria Plan. A cafeteria plan that meets the requirements of Title 26, Subtitle A, Chapter 1, Subchapter B, Part III, Section 125 of the Internal Revenue Code.

Seasonal Employee. An individual hired to perform services for wages by a seasonal employer certified under M.G.L. c. 151A during the seasonal period in the employer's seasonal operations for a specific temporary seasonal period; whose employment is limited to the period between the beginning and ending dates of the employer's seasonal period' and whose employment does not exceed 16 weeks.

Temporary Employee. An individual that works for an Employer on either a full or part time basis; whose employment is explicitly temporary in nature and does not exceed 12 consecutive weeks during the period from October 1 through September 30.

18.03 Employer HIRD Report

(1) General Requirements. Each Massachusetts Employer with eleven or more Full Time Equivalent Employees shall report the following information in an Employer HIRD Report specified by the Division.

(a) Reporting Employer. An Employer has eleven or more Full Time Equivalent Employees if the sum of total payroll hours for all Employees for a calendar quarter, divided by 500, is greater than or equal to eleven. In calculating payroll hours:

1. For each Employee with more than 500 payroll hours for the Employer, the Employer shall include 500 payroll hours.
2. Payroll hours include all hours for which an Employer paid wages including, but not limited to, regular, vacation, sick, Federal Medical Leave of Absence, short term disability, long term disability, overtime and holiday hours.
3. The Employer shall include the payroll hours of Seasonal Employees but shall not include the payroll hours of Independent Contractors as defined in 114.5 CMR 18.02.
4. An Employer who is determined to be a successor under M.G.L. c. 151A shall include the payroll hours of the predecessor's Employees during the determination period.

(b) Required information. Each Reporting Employer is required to report the following information:

1. Employer Legal Name
2. Employer DBA Name
3. Employer FEIN
4. Division of Unemployment Assistance Account Number
5. Whether the Employer adopts and/or maintains a Section 125 Cafeteria Plan in accordance with the requirements of the Connector
6. Whether the employer collects Employee HIRD forms from employees that decline to participate in group health plan or Section 125 plan
7. Whether the Employer contributes to the premium cost of a group health plan for its Employees
8. If the Employer contributes to the premium cost of a group health plan for its Employees, the employer contribution percentage for each employee category if the percentage varies by category.
9. If the Employer contributes to the premium cost of a group health plan for its Employees, the total monthly premium cost for the lowest priced health insurance offered for an individual plan and a family plan.
10. If the Employer offers an Employer sponsored group health plan, the open enrollment period of the Employer sponsored plan
11. Information about the Employer's full-time criteria:
    (i) payroll hours per week does your firm require an employee to work to be considered full time
    (ii) minimum number of payroll hours per week that firm requires an employee to work to be considered eligible for full-time health plan benefits
    (iii) whether firm offers participation in a multiemployer health plan to any full-time employees during the applicable base period
    (iv) how many months a full-time employee must work at firm before he or she is eligible for health benefits?

(c) Employee Leasing Company Arrangements. If and to the extent there is an arrangement between Client Company and an Employee Leasing Company, the Client Company is the Employer for purposes of M.G.L. c. 118G with respect to itself and its Employees covered by the arrangement. Nothing in 114.5 CMR

18.00 prohibits the Client Company from executing an agreement with the Employee Leasing Company that assigns responsibility for filing the Client Company's Employer HIRD Report to the Employee Leasing Company. If the Employee Leasing Company fails to comply with such an agreement, the Client Company will continue to be responsible for compliance with 114.5 CMR 18.00. If an Employee Leasing Company files the Employer HIRD Report on behalf of its Client Companies, it shall file a separate report for each Client Company.

(2) Required Filings

(a) Due Dates. Each Reporting Employer shall submit its Employer HIRD Report with its Fair Share Contribution filing in accordance with the filing requirements of the Division of Unemployment Assistance. If an Employer is permitted to submit the Fair Share Contribution filing once a year, the Employer may file only one Employer HIRD Report per year. .

(b) Employer Attestation. All Employer HIRD reports shall be made under the pains and penalties of perjury. A Reporting Employer must designate a responsible individual authorized to verify and certify the accuracy of the Employer HIRD information submitted.

(c) The Division may change reporting requirements, including specified forms and filing deadlines by administrative bulletin.

(3) Data Verification

(a) Verification. Each Reporting Employer must submit any additional documentation requested by the Division to verify the accuracy of the data submitted.

(b) Audit. The Division may, upon notice to the Reporting Employer, inspect and copy any records necessary to verify the accuracy of the information submitted.

(c) Data Matches. The Division will initiate data matches, as permitted by law, with the Division of Unemployment Assistance and the Department of Revenue to verify the accuracy of the data submitted by the reporting Employer.

18.04 Employee HIRD Form

(1) General Requirements. Each Reporting Employer must provide an Employee HIRD Form for completion and signature by each Employee that declines to enroll in Employer-sponsored insurance or declines to use the Employer's Section 125 Cafeteria Plan to pay for health insurance. Each time an Employee of a Reporting Employer declines to enroll in Employer sponsored insurance or declines to use the Reporting Employer's Section 125 Plan to pay for health insurance, the Employee is required to complete, sign and return an Employee HIRD Form to the Reporting Employer.

(a) Reporting Employer. An employer is required to collect signed Employee HIRD Forms if it has either 5,500 payroll hours in any quarter or 22,000 payroll hours in a year.

(b) Required Information. The Employee HIRD Form must contain the following information:

1. Employee Name
2. Employer Name

3. Whether the Employee was informed about the Employer's Section 125 Cafeteria Plan
4. Whether the Employee declined to use the Employer's Section 125 Cafeteria Plan to pay for health insurance
5. Whether the Employee was offered Employer subsidized health insurance
6. Whether the Employee declined to enroll in Employer subsidized health insurance
7. If the Employee declined Employer subsidized health insurance, the dollar amount of employee's portion of the monthly premium cost of the least expensive individual health plan offered by the Employer to the Employee
8. Whether the Employee has alternative insurance coverage.
9. The Employee's signature and the date on which the Employee signs the HIRD form

(c) Required Acknowledgements.

1. The Employee must acknowledge that he or she has declined to enroll in Employer sponsored insurance and/or has declined to use the Employer's Section Cafeteria 125 Plan to pay for health insurance.
2. The Employee must acknowledge that if he or she declines an Employer offer of subsidized health insurance, he or she may be liable for his or her health care costs.
3. The Employee must acknowledge that he or she is aware of the individual mandate under M.G.L. c. 111M and the penalties for failure to comply with the individual mandate.
4. The Employee must acknowledge that he or she is required to maintain a copy of the signed HIRD Form and that the HIRD Form contains information that must be reported in the Employee's Massachusetts tax return.
5. The Employee must indicate that by his or her signature, he or she acknowledges the truthfulness of his or her answers.

(2) HIRD Form.

(a) Form Availability; Versions. The Division will make available the Employee HIRD Form to Reporting Employers by posting the Form on the Division's website. The Division may revise the Employee HIRD Form from time to time. When an Employee is required to sign the Employee HIRD Form, the Reporting Employer must provide the Employee with the current version of the Employee HIRD form as posted on the website on the date of signature. A Reporting Employer is not required to have Employees sign an updated version of the Division's Employee HIRD Form if the Employee signed the version in effect on the date of signature. .

(b) Alternative Form. A Reporting Employer may collect the required information and acknowledgements from its Employees in any form or manner, including any electronic or other alternative media form that it deems necessary or appropriate; provided that the alternative form contains all of the required data elements listed in 114.5 CMR 18.04(1) and the same wording, order, and

sequence and numbering of questions as they appear on the Employee HIRD Form version posted on the Division's website.
(c) Electronic Signatures. An Employee may sign an Employee HIRD Form using an electronic signature; provided such signature complies with applicable federal and state law.

(3) The Reporting Employer must retain the signed Employee HIRD Form for a period of three years.
(a) The Reporting Employer must make available to the Division and the Department of Revenue copies of signed Employee HIRD Forms or Alternative Forms for inspection and audit. The Reporting Employer must submit a copy of an Employee HIRD Form to the Division or the Department of Revenue upon request.
(b) If the Employee does not comply with the Reporting Employer's request to complete and return a signed Employee HIRD Form, the Repoting Employer must document diligent efforts to obtain such Form and maintain the documentation for a period of three years.
(c) Additional Documentation. The Reporting Employer must create and retain documentation for those Employees who are not required to sign an Employee HIRD Form for a period of three years, including Employees enrolled in the Reporting Employer's sponsored health plan and Employees not eligible for the Reporting Employer's Section 125 Cafeteria Plan in accordance with 956 CMR 4.06(3)(b)4.

(4) Due Date.
(a) Annual Open Enrollment. The Reporting Employer must obtain a signed Employee HIRD Form from each Employee required to sign a Form by the earlier of 30 days after the close of the applicable open enrollment period for the Reporting Employer's health insurance, and/or its Section 125 Cafeteria Plan, or September 30 of the reporting year. If an Employer's open enrollment period for 2007 - 2008 ended prior to July 1, 2007, and an Employee has signed an Employer form acknowledging that he or she was offered and declined Employer sponsored insurance, such Employee is not required to sign an Employee HIRD Form until the next applicable due date, in accordance with this 114.5 CMR 18.04(4), occurring on or after July 1, 2007. If and to the extent the Employer form is effective for any period on or after July 1, 2007, the Employer must retain the signed Employer form until July 1, 2009.
(b) Change in Status Terminations. If an Employee who enrolled in an Employer sponsored health insurance plan subsequently terminates participation in the plan between applicable enrollment periods in accordance with the reporting Employer's Section 125 cafeteria Plan (and remains employed by the Reporting Employer), the Employee must sign an Employee HIRD Form within 30 days of the date participation terminated.
(c) New Hire Enrollment. The Reporting Employer must obtain the signed Employee HIRD Form from each new Employee that either declines Employer sponsored health insurance or declines to use the Employer's Section 125 Cafeteria Plan to pay for health insurance within 30 days of the close of the applicable new hire enrollment period.

(5) Signed Copy to Employee. The Reporting Employer must automatically provide a copy of each signed Employee HIRD Form to the Employee. The Reporting Employer must, upon request, provide a copy of the Employee's signed Employee HIRD Form to the Employee for use in filing the Employee's Massachusetts income tax return.

18.05 Other Provisions

(1) Information that identifies individual Employees by name or health insurance status shall not be a public record, but such information may be exchanged with the Department of Revenue, the Health Care Access Bureau of the Division of Insurance, the Division of Unemployment Assistance, or the Commonwealth Health Insurance Connector Authority to extent permitted by law under an Interagency Service Agreement.

(2) Penalties. An Employer that knowingly falsifies or fails to file any information required by the Division shall be punished by a fine of not less than $1,000 or more than $5,000.

(3) Severability. The provisions of 114.5 CMR 18.00 are severable. If any provision or the application of any provision is held to be invalid or unconstitutional, and such invalidity shall not be construed to affect the validity or constitutionality of any remaining provisions of 114.5 CMR 18.00 or the application of such provisions.

(2) Administrative Bulletins. The Division may issue administrative bulletins to clarify policies, update administrative requirements and specify information and documentation necessary to implement 114.5 CMR 18.00.

REGULATORY AUTHORITY
114.5 CMR 18.00 M.G.L. c. 118G.

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Division of Health Care Finance and Policy

Employee Health Insurance Responsibility Disclosure Form 2009

You are completing this form because you have declined to participate in your employer sponsored health insurance plan and/or have declined to participate in the employer's "Section 125 Cafeteria Plan" pre-tax purchasing arrangement. A Section 125 Plan is not health insurance; it is a way to purchase health insurance on a pre-tax basis. For information about affordable health insurance options, visit the Commonwealth Connector at < www.mahealthconnector.org >.

Employer

Employers: please complete this section. See reverse side for instructions.

Employer Name: _____ **FEIN:** _____

Employer D/B/A: _____

Employer Address: _____

City | State | ZIP Code: _____

1. Did you offer employer sponsored health insurance to this employee? Yes ☐ No ☐
2. Did you offer a "Section 125 Cafeteria Plan" to this employee? Yes ☐ No ☐
3. What is the dollar amount of the employee's portion of the monthly premium cost of the least expensive individual health plan offered by the employer to the employee? $ _____

Employee

Employees: please complete this section. See reverse side for instructions.

Employee First Name | **Middle Initial**

Employee Last Name | **Suffix** (e.g., Sr., Jr.)

Employee Social Security or Tax Identification Number

☐☐☐ — ☐☐ — ☐☐☐☐

1. Did you accept your employer sponsored health insurance? Yes ☐ No ☐ None Offered ☐
2. Did you agree to use your employer's "Section 125 Cafeteria Plan" to purchase health insurance? Yes ☐ No ☐ None Offered ☐
3. Do you have other health insurance? Yes ☐ No ☐

Employee Affidavit

I hereby affirm, under penalties of perjury, that all the information provided herein is true to the best of my knowledge. I also understand that if I do not have health insurance I may be responsible for the full costs of all medical treatment, that I may forfeit all or a portion of my Massachusetts personal tax exemption and be subject to other penalties pursuant to M.G.L c. 111M, that the Employee Health Insurance Responsibility Disclosure (HIRD) Form contains information that must be reported in my Massachusetts tax return, and that I am required to maintain a copy of the signed HIRD Form.

Employee Signature _____

Date (MM/DD/YY) ☐☐/☐☐/☐☐

The employer must retain this document for three (3) years and make it available upon request to the Division of Health Care Finance and Policy and the Division of Revenue as required by state regulation 114.5 CMR 18.00.

DHCFP-EHIRD09

Instructions

Employer Information

Employer Name
Employers must enter the company's legal name.

FEIN
The employer must enter the Federal Employer Identification Number.

D/B/A
The employer must enter the company's trade name "Doing Business As" here, if applicable.

Employer Address
The employer must enter the business address including city, state, and ZIP Code.

Question 1
The employer must indicate either Yes or No (check box).

Question 2
The employer must indicate either Yes or No (check box).

Question 3
The employer must report the dollar amount of the employee's portion of the monthly premium cost of the least expensive individual health plan offered by the employer to the employee.

Employee Information

Employee First Name
The employee or employer must enter the employee's first name.

Employee Last Name
The employee or employer must enter the employee's last name.

Employee Social Security or Tax Identification Number
The employee or employer must enter the employee's Social Security or Tax Identification Number.

Question 1
The employee must indicate Yes, No, or None Offered if health insurance is not offered (check box).

Question 2
The employee must indicate Yes, No, or None Offered if a "Section 125 Cafeteria Plan" is not offered (check box).

Question 3
The employee must indicate Yes or No (check box).

Employee Signature
The employee must sign and date the Employee Health Insurance Responsibility Disclosure (HIRD) form.

Note to Employer Regarding Employee Signature
If the employee refuses to sign and date the form, the refusal should be noted in writing and signed by the authorized company representative (e.g., the owner, supervisor or manager, chief executive officer, etc.).

Alternate Versions of This Form

Employers may recreate their own version of the Employee Health Insurance Responsibility Disclosure (HIRD) form. However, all information must be included, with the same wording and order, and the sequence and numbering of the Questions must be exactly as it appears on the version provided by the Commonwealth of Massachusetts.

The Commonwealth of Massachusetts
Oficina Ejecutiva de Servicios Humanos y de la Salud
División de Finanzas y Políticas de la Atención Médica

Formulario de declaración de la responsabilidad del seguro médico del empleado 2009

Usted completa este formulario porque ha rechazado participar en el plan del seguro médico patrocinado por su empleador y/o ha rechazado participar en el acuerdo de compra previo al cálculo de los impuestos "Plan Cafetería Sección 125" de su empleador. Un Plan Sección 125 no es un seguro médico; es una manera de comprar seguro médico previo al cálculo de los impuestos. Para obtener información sobre opciones económicas de seguro médico, visite la Commonwealth Connector en < www.mahealthconnector.org >.

Sección del empleador

Empleadores: Por favor, complete esta sección. Vea las instrucciones más abajo.

Nombre del empleador: _____

Número federal de identificación como empleador (FEIN por sus siglas en inglés): _____

Nombre comercial del empleador: _____

Dirección del empleador: _____

Ciudad |Estado |Código postal: _____

1. ¿Ofreció un seguro médico patrocinado por el empleador a este empleado? Sí ☐ No ☐
2. ¿Ofreció un "Plan Cafetería Sección 125" a este empleado? Sí ☐ No ☐
3. ¿Cuál es el monto en dólares de la parte del empleado del costo mensual de la prima del plan médico individual menos costoso ofrecido por el empleador al empleado? $ ☐

Sección del empleado

Empleados: Por favor, complete esta sección. Vea las instrucciones más abajo.

Nombre del empleado ☐ **Inicial** ☐

Apellido del empleado ☐ **Sufijo** ☐

Número de identificación impositiva o del Seguro Social del empleado

☐☐☐ — ☐☐ — ☐☐☐☐

1. ¿Aceptó el seguro médico patrocinado por su empleador? Sí ☐ No ☐ No ofreció ninguno ☐
2. ¿Estuvo de acuerdo en usar el "Plan Cafetería Sección 125" de su empleador? Sí ☐ No ☐ No ofreció ninguno ☐
3. ¿Tiene otro seguro médico? Sí ☐ No ☐

Testimonio del empleado

Afirmo por la presente, bajo penalidad por falso testimonio, que toda la información provista aquí es veraz según mi conocimiento. También entiendo que si no tengo seguro médico podría ser responsable por el costo total de todo el tratamiento médico, que podría perder una parte o toda mi exención impositiva personal de Massachussets y quedar sujeto a otras penalidades según la Ley General de Massachussets, c. 111M que el Formulario de declaración de la responsabilidad del seguro médico del empleado incluye información que debe incluirse en mi declaración impositiva de Massachussets y que debo guardar una copia del formulario firmado.

Firma del empleado ☐

Fecha (MM/DD/AA) ☐☐/☐☐/☐☐

El empleado debe guardar este documento durante tres (3) años y ponerlo a disposición si lo solicita la División de Finanzas y Políticas de la Atención Médica y la División de Rentas según lo requiera la reglamentación del estado 114.5 CMR 18.00.

Instrucciones

INFORMACIÓN DEL EMPLEADOR

Nombre del empleador
El empleador debe indicar el nombre legal de la compañía.

Número federal de identificación como empleador (FEIN por sus siglas en inglés)
El empleador debe indicar el número federal de identificación como empleador.

Nombre comercial
El empleador debe indicar el nombre comercial de la empresa, si corresponde.

Dirección del empleador
El empleador debe indicar la dirección comercial incluyendo la ciudad, estado y código postal.

Pregunta 1
El empleador debe indicar Sí o No.

Pregunta 2
El empleador debe indicar Sí o No.

Pregunta 3
El empleador debe declarar el monto en dólares de la parte del empleado del costo mensual de la prima del plan médico individual menos costoso ofrecido por el empleador al empleado.

INFORMACIÓN DEL EMPLEADO

Nombre del empleado
El empleado o empleador debe indicar el nombre del empleado.

Apellido del empleado
El empleado o empleador debe indicar el apellido del empleado.

Número de identificación impositiva o del Seguro Social del empleado
El empleador o empleador debe indicar el número de identificación impositiva o del Seguro Social del empleado.

Pregunta 1
El empleado debe indicar Sí, No o Ninguno ofrecido si no se ofrece seguro médico.

Pregunta 2
El empleado debe indicar Sí, No o Ninguno ofrecido si no se ofrece un "Plan Cafetería Sección 125".

Pregunta 3
El empleado debe indicar Sí o No.

Firma del empleado
El empleado debe firmar y fechar el Formulario de declaración de la responsabilidad del seguro médico del empleado (HIRD por sus siglas en inglés).

Nota al empleador sobre la firma del empleado
Si el empleado rehúsa firmar y fechar el formulario, el rechazo debe hacerse constar por escrito y firmado por un representante autorizado de la compañía (por ej., el dueño, supervisor o gerente, jefe ejecutivo, etc.).

VERSIONES ALTERNATIVAS DE ESTE FORMULARIO

Los empleadores pueden recrear su propia versión del Formulario de declaración de la responsabilidad del seguro médico del empleado. Sin embargo, se debe incluir toda la información, con las mismas palabras y orden y la secuencia y numeración de las preguntas debe ser exactamente igual a lo que aparece en la versión aprobada por la Commonwealth of Massachusetts.

Estado de Massachusetts
Escritório Executivo de Serviços Humanos e de Saúde
Divisão de Política e Finanças para Tratamento de Saúde

Formulário de Esclarecimento sobre a Responsabilidade do Funcionário no Seguro de Saúde para 2009

Você está preenchendo este formulário porque se recusou a participar do plano de seguro de saúde patrocinado por seu empregador e/ou se recusou a participar do contrato de compra do empregador antes da tributação conforme "Section 125 Cafeteria Plan" (Plano da seção 125 – 'Cafeteria'). O Plano da Seção 125 ('Section 125 Plan') não corresponde a um seguro de saúde; trata-se de um modo de adquirir seguro de saúde com base de cálculo anterior à tributação. Para informações sobre opções acessíveis para o seguro de saúde, consulte o site 'Commonwealth Connector' no endereço:< www.mahealthconnector.org >.

Seção do empregador

Empregadores: Por favor, preencha esta seção. Veja as instruções a seguir.

Nome do empregador: _____ **FEIN:** _____

Nome de fantasia do empregador (D/B/A): _____

Endereço do empregador: _____

Cidade | Estado | Código Postal (ZIP): _____

1. A empresa ofereceu plano de saúde patrocinado pelo empregador a este funcionário? Sim ☐ Não ☐
2. A empresa ofereceu um Plano da Seção 125 ("Section 125 Cafeteria Plan") para este funcionário? Sim ☐ Não ☐
3. Qual o valor em dólares da parcela do funcionário relativa ao custo mensal do prêmio do plano de saúde individual mais barato que o empregador ofereceu ao funcionário? $ ☐

Seção do funcionário

Funcionários: Por favor, preencha esta seção. Veja as instruções a seguir.

Nome do funcionário ☐ **Inicial do meio** ☐

Último sobrenome do funcionário ☐ **Sufixo** ☐

Número do seguro social (SS) ou identificação tributária (ITIN) do funcionário

☐☐☐ — ☐☐ — ☐☐☐☐

1. Você aceitou o seguro de saúde patrocinado pelo seu empregador? Sim ☐ Não ☐ Nada foi oferecido ☐
2. Você concordou em usar o Plano da Seção 125 ("Section 125 Cafeteria Plan") do seu empregador? Sim ☐ Não ☐ Nada foi oferecido ☐
3. Você tem algum outro seguro de saúde? Sim ☐ Não ☐

Atestado do funcionário

Por este instrumento, atesto, sujeito às penalidades por falso testemunho, que todas as informações aqui fornecidas são verdadeiras até onde seja do meu conhecimento. Estou ciente também de que se não tiver seguro de saúde poderei ser responsável por todos os custos de qualquer tratamento de saúde, poderei perder toda ou uma parcela da minha isenção tributária pessoal do Estado de Massachusetts e ficarei sujeito a outras penalidades conforme a legislação M.G.L c. 111M, que o Formulário de Esclarecimento sobre a Responsabilidade do Funcionário no Seguro de Saúde (HIRD em inglês) contém informações que preciso comunicar através da minha declaração de impostos ao Estado de Massachusetts e que sou obrigado a manter uma cópia do formulário HIRD assinado.

Assinatura do funcionário ☐ **Data (MM/DD/AA)** ☐☐/☐☐/☐☐

O empregador é obrigado a manter este documento durante três (3) anos e colocá-lo à disposição mediante solicitação junto à Divisão de Política e Finanças para Tratamento de Saúde e à Divisão da Receita, conforme disposto no regulamento estadual 114.5 CMR 18.00.

Instruções

INFORMAÇÕES DO EMPREGADOR

Nome do empregador
O empregador deve preencher com o nome oficial da empresa.

FEIN (Federal Employer Identification Number)
O empregador deve preencher com o número de identificação federal do empregador.

Nome de fantasia ("Doing Business As" – D/B/A)
O empregador deve preencher com o nome comercial ou de fantasia da empresa, se pertinente.

Endereço do empregador
O empregador deve preencher com o endereço da empresa, inclusive a cidade, estado e código postal.

Perguntas #1
O empregador deve indicar Sim ou Não.

Perguntas #2
O empregador deve indicar Sim ou Não.

Perguntas #3
O empregador deve comunicar o valor em dólares da parcela do funcionário relativa ao custo mensal do prêmio do plano de saúde individual mais barato que o empregador ofereceu ao funcionário.

INFORMAÇÕES DO FUNCIONÁRIO

Nome do funcionário
O funcionário ou o empregador devem preencher com o nome do funcionário.

Último sobrenome do funcionário
O funcionário ou o empregador devem preencher com o último sobrenome do funcionário.

Número do seguro social (SS) ou identificação tributária (ITIN) do funcionário
O funcionário ou o empregador devem preencher com o número do seguro social (SS) ou identificação tributária (ITIN) do funcionário.

Perguntas #1
O funcionário deve indicar Sim, Não ou Nada foi oferecido, caso não tenha sido oferecido nenhum seguro de saúde.

Perguntas #2
O funcionário deve indicar Sim, Não ou Nada foi oferecido, caso não tenha sido oferecido nenhum Plano da Seção 125.

Perguntas #3
O funcionário deve indicar Sim ou Não.

Assinatura do funcionário
O funcionário deve assinará e datar o Formulário de Esclarecimento sobre a Responsabilidade do Funcionário no Seguro de Saúde (HIRD).

Observação para o empregador sobre a assinatura do funcionário
Se o funcionário se recusar a assinar e datar o formulário, esta recusa deve ser registrada por escrito e assinada pelo representante autorizado da empresa (ou seja, o proprietário, supervisor ou gerente, diretor geral, etc.).

VERSÕES ALTERNATIVAS DESTE FORMULÁRIO

Os empregadores podem criar suas próprias versões do Formulário de Esclarecimento sobre a Responsabilidade do Funcionário no Seguro de Saúde (HIRD). Entretanto, todas as informações devem estar incluídas com a mesma redação e na mesma ordem, com a seqüência e numeração das perguntas exatamente iguais às que aparecem na versão fornecida pelo Estado de Massachusetts.

Section 8
Insured Plan Requirements

Fact Sheet: Fully Insured Plans Written in Massachusetts: Dependent Eligibility

Fact Sheet: Fully Insured Plans Written in Massachusetts: Offer of Coverage and Nondiscrimination in Contributions

Division of Insurance Bulletin 2007-01 – Dependent Eligibility

Division of Insurance Bulletin 2008-01 – Dependent Eligibility Amendments

Division of Insurance Bulletin 2007-04 – Nondiscrimination

Department of Revenue TIR 07-16: Personal Income Tax Treatment of Employer-Provided Health Insurance Coverage for an Employee's Child

Associated Industries of Massachusetts

Fact Sheet

The Massachusetts Health Care Reform Law

Fully Insured Plans Written in Massachusetts: Dependent Eligibility

Status of Regulations:	Regulatory Bulletin finalized January 18, 2007
Administrative Agency:	Massachusetts Division of Insurance
Effective Date:	January 1, 2007

General Purpose

The Health Care Reform Act requires that insured group health benefit plans written in Massachusetts provide for dependent coverage through their 26th birthday or at the end of two full calendar years following the loss of dependent status according to IRS Code §106, whichever comes first.

Loss of Dependent Status

§106 defines who may be covered under employer-sponsored insurance plans on a tax-favored basis. It does not define who may be claimed as a dependent on a federal income tax return.

See Division of Insurance Bulletin dated Jan. 15, 2008, included in this Section, for excellent examples of exactly how eligibility is determined.

Imputed Income Issue

§106 establishes that employers may provide tax-free benefits to individuals who meet the definition of either a "qualifying child" or a "qualifying relative."

For individuals not meeting either definition, the "fair market value" of the coverage provided through an employer-sponsored plan is taxable to the employee as imputed income and is subject to federal income tax as well as the employer and employee portions of Social Security and Medicare taxes. (The value of coverage is explicitly exempt from Massachusetts state income tax.)

Administrative Issues

The issue of imputed income arises frequently for employers that provide coverage voluntarily (i.e., domestic partners) or under state mandates (i.e., same-sex spouses, ex-spouses and, now, some dependent children) to individuals who are not eligible for tax-free coverage under federal and/or state law. To simplify administration, AIM encourages employers to first determine eligibility under plan rules and/or mandates and then to examine the taxation issue for each individual.

Employers are encouraged to consult with their tax/legal/benefits advisors since there are multiple methods of determining the "fair market value" of coverage.

Failure to deal with imputed income issues results in underpayment of federal and/or state income taxes as well as underpayment of both employee and employer portions of Social Security and Medicare taxes.

Employee Education

Care must be taken to ensure that employees are provided information that enables them to make fully-informed decisions about their benefit elections. Communications should include information related to both eligibility rules and the potential tax implications of their elections.

Associated Industries of Massachusetts

Fact Sheet

The Massachusetts Health Care Reform Law

Fully Insured Plans Written in Massachusetts: Offer of Coverage and Nondiscrimination in Contributions

Status of Regulations:	Final Division of Insurance Bulletin – April 11, 2007
Administrative Agency:	Division of Insurance
Effective Date:	For all group contracts signed on or after July 1, 2007

General Requirements

Health insurance carriers in Massachusetts are prohibited, effective July 1, 2007, from entering into a group contract with an employer unless:

1. The employer offers that group health benefit plan to all of its full-time employees who live in Massachusetts; and
2. The employer does not make a smaller percentage premium contribution for its lower paid employees than it does for higher paid employees.

"Full-time" is very specifically defined as any employee who is expected or scheduled to work 35 or more hours per week. "Temporary" and "seasonal" employees, as defined under the health care reform law, are not considered to be full-time.

When are premium contribution differentiations permitted?

The following are permitted:

- Differences covered by a collective bargaining agreement
- Higher contributions for lower paid employees
- Fixed dollar amount for each employee regardless of salary
- Different contributions based on part-time vs. full-time status
- Different contribution levels for different plans (but no discrimination among full-time within each plan)
- Higher contributions based on bona-fide longevity – should not be implemented to circumvent the nondiscrimination requirement
- Higher contribution levels for employees who participate in company-sponsored wellness programs

COMMONWEALTH OF MASSACHUSETTS
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ACTING COMMISSIONER OF INSURANCE

Bulletin 2007-01

TO: **Insurers Offering Insured Health Products in Massachusetts, Blue Cross and Blue Shield of Massachusetts and Health Maintenance Organizations**

FROM: **Joseph G. Murphy, Acting Commissioner of Insurance**

DATE: **January 18, 2007**

RE: **Amendments Created by Chapters 58 of the Acts of 2006, as amended, Related to Eligibility as a Dependent in an Insured Health Plan**

The purpose of this bulletin is to clarify the new dependent coverage requirements implemented under the Health Care Reform Act.

Effective January 1, 2007, the Health Care Reform Act (Chapter 58 of the Acts of 2006, as amended) requires that carriers with insured health benefit plans that provide for dependent coverage make coverage available for persons through the earlier of their 26th birthday or the day two (2) years following the loss of their dependent status according to federal tax rules.

This requirement applies to all insured health plans offered by commercial insurance companies, Blue Cross and Blue Shield of Massachusetts (BCBSMA), and Health Maintenance Organizations, except for stand-alone dental products and Medicare Supplement plans. Insured health plans that provide or arrange for the delivery of health care services through a defined network of providers would be permitted, however, to restrict coverage to those persons, including dependents, who maintain residence within the plan service area.

As of January 1, 2007, carriers may not impose any limitations on eligibility for dependent coverage, other than limitations defining familial relationships under the policy (e.g., spouse and children, or spouse, children and parents) and any other limitations that may be permitted under the statute.

Determination of Loss of Dependent Status

To qualify as a dependent under an insured health plan, an individual must have satisfied the Internal Revenue Code criteria for dependent status and must have been claimed as a dependent on: (1) a subscriber's federal income tax form, or (2) 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.

For the purpose of determining the date of a person's "loss of dependent status", the Division will follow the Internal Revenue Code's calendar year designation (i.e., January 1 through December 31). The date on which a person loses dependent status is December 31 of the last federal tax year for which said person was claimed as a dependent on another person's federal income tax form.

Carriers are required to continue dependent coverage until December 31, two years following the date of "loss of dependent status", for those persons under 26 years of age.

The following scenarios are provided to help illustrate the effect of these new provisions:

Scenario 1
As an example, consider the case of a 22-year old who has been a dependent of her parents, gets a job, and moves out of her parents' home on November 1, 2006. When her parents complete their tax return in 2007 for tax year 2006, they will continue to declare her as a dependent provided that she satisfied the Internal Revenue Code's qualifications as a dependent for 2006. If she continues to live away from home, paying more than half of her living expenses for tax year 2007, when her parents complete their tax return for tax year 2007 in 2008, they will not be able to declare her as a dependent for tax year 2007. She, therefore, will have lost her "dependent status" on December 31, 2006, the day before the year in which she cannot be considered as a "dependent" under her parents' federal tax return. This would mean that she would be eligible to continue as a dependent under her parents' health insurance through December 31, 2008 – two years after the December 31, 2006 loss of dependent status.

Scenario 2
The 22-year old who moved out on November 1, 2006 in Scenario 1, subsequently moves back home on June 15, 2007 and her parents pay for more than half of her living expenses for tax year 2007. When her parents complete their tax return for tax year 2007 in 2008, they will continue to declare her as a dependent for tax year 2007. She, therefore, will not have lost her "dependent status" despite the fact that she may have

lived on her own from November 1, 2006 through June 15, 2007 because her parents declared her as a dependent on their 2007 tax return forms.

Scenario 3

The 22-year old who moved out on November 1, 2006 in Scenario 1, subsequently moves back home on January 1, 2008 and her parents pay for more than half of her living expenses for tax year 2008. Her parents will again claim her as a dependent on their 2008 federal income tax form. When her parents complete their tax return for tax year 2007 in 2008, they will not declare her as a dependent for tax year 2007 since she did not meet the "dependent status" under federal tax law. This would mean that she lost her "dependent status" on December 31, 2006 and then would only be eligible to continue dependent coverage until December 31, 2008, or two years following the loss of dependent status. In this case, however, as the daughter moves back home on January 1, 2008, prior to the expiration of the "two year period following loss of dependent status" and she requalifies as a dependent for tax year 2008 when her parents complete their tax forms in 2009, she then will continue as a "dependent" under her parents' coverage without interruption until the earlier of her 26th birthday or two years following the next loss of dependent status.

Scenario 4

The 22-year old who moved out on November 1, 2006 in Scenario 1, had a child in November 2007 and subsequently moves back home on January 1, 2008 with her parents who pay for more than half of her living expenses in tax year 2008. As noted above, since the daughter moves back home prior to the expiration of the two-year period following loss of dependent status, she then will continue as a "dependent" under her parents' coverage without interruption until the earlier of her 26th birthday or two years following the next loss of dependent status. Regarding the child born in November 2007, under other insurance statutes, carriers are required to cover the newborn child of a dependent. Since the daughter is a dependent under the plan, the newborn child would also qualify as a dependent under the plan for as long as the dependent daughter is eligible for dependent coverage. Therefore, once the daughter loses dependent status, the grandchild is no longer eligible for dependent status under the grandparents' plan. Unless grandchildren are normally considered eligible dependents under the plan, independent of their parents, the two year rule does not apply to the grandchild in this case.

Enrollment Period

All carriers offering insured health plans with dependent coverage shall consider January 1, 2007 as a qualifying event and shall provide persons who become newly eligible for dependent coverage on January 1, 2007, under M.G.L. c. 175, § 108(2)(a)(3); M.G.L. c. 175, § 110(P); M.G.L. c. 176A, § 8Z; M.G.L. c. 176B, § 4Z; and M.G.L. c. 176G, § 4R, a reasonable initial eligibility enrollment period. Following the expiration of such an initial eligibility period, carriers are required to offer such eligible persons coverage during open enrollment periods or upon a qualifying event in the same manner that all other eligible dependents are offered such coverage.

Carriers subject to M.G.L. c. 176O and 211 CMR 52.00, or M.G.L. c. 175 § 108, should forward to the Division any changes to evidences of coverage on file with the Division to reflect changes to sections addressing eligibility as a dependent to comply with those statutory provisions as implemented by Chapters 58.

Eligibility for Continuation Coverage

Under federal law for employers with 20 or more employees and under M.G.L. c. 176J, § 9 for employer groups with between 2 and 19 employees, 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 ceas[es] to be a dependent child under the generally applicable requirements of the health benefit plan." For the purposes of rights to continue coverage as a dependent, the date of the qualifying event will be the earlier of the 26th birthday or the date two years after the loss of dependent status. If a 22-year old child loses her dependent status under federal tax rules as of December 31, 2006 and continues to not qualify as a dependent on her parents' tax return forms, her qualifying event date for purposes of COBRA or mini-COBRA would be December 31, 2008, the last day she would be guaranteed eligible under her parent's insured health coverage.

If there are any questions regarding this bulletin, please contact Nancy Schwartz, Director of the Bureau of Managed Care at (617) 521-7347 or Kevin Beagan, Director of the State Rating Bureau at (617) 521-7323.

2008-01 Amendments Created by Chapter 205 of the Acts of 2007 Related to Eligibility as a Dependent in an Insured Health Plan

TO: **Commercial Health Insurers, Blue Cross and Blue Shield of Massachusetts, Inc., and Health Maintenance Organizations Offering or Renewing Insured Health Products in Massachusetts**

FROM: **Nonnie S. Burnes, Commissioner of Insurance**

DATE: **January 15, 2008**

RE: **Amendments Created by Chapter 205 of the Acts of 2007 Related to Eligibility as a Dependent in an Insured Health Plan**

Chapter 205 of the Acts of 2007 provided additional technical corrections to the Health Care Reform Act, Chapter 58 of the Acts of 2006. The purpose of this bulletin is to inform all commercial health insurers, Blue Cross and Blue Shield of Massachusetts, Inc., and Health Maintenance Organizations (collectively "carriers") of the new provisions related to eligibility as a dependent in an insured health plan. The Division of Insurance ("Division") issues this Bulletin 2008-01 to replace, effective of January 1, 2008, the Division's prior Bulletin 2007-01.[1]

Qualified Dependent

Effective January 1, 2008, carriers with insured health plans, except for stand-alone dental products and Medicare Supplement plans, that provide for dependent coverage must make coverage available for persons "under 26 years of age or for two (2) years after the end of the calendar year in which such persons last qualified as dependents under 26 U.S.C. 106, whichever occurs first."[2] The reference to 26 U.S.C 106 is section 106 of the Internal Revenue Code ("IRC"). An individual is considered a dependent for purposes of dependent coverage under an insured health plan if the individual qualifies as a dependent under section 106 of the IRC.[3]

Carriers may not impose any limitations on eligibility for dependent coverage, other than limitations defining familial relationships under the policy (e.g., spouse and children, or spouse, children and parents) and any other limitations that may be permitted under the statute. Insured health plans that provide or arrange for the delivery of health care services through a defined network of providers would be permitted, however, to restrict coverage to those persons, including dependents, who maintain residence within the plan service area. Any child of divorced parents who meets the expanded definition of dependent in connection with one parent is treated as a dependent of both parents.

Enrollment Period

Carriers are required to offer such eligible persons coverage during open enrollment periods or upon a qualifying event in the same manner that all other eligible dependents are offered such coverage.

Carriers subject to M.G.L. c. 176O and 211 CMR 52.00, or M.G.L. c. 175 § 108, should forward to the Division any changes to evidences of coverage on file with the Division to reflect changes to sections addressing eligibility as a dependent to comply with those statutory provisions as implemented by Chapter 205 of the Acts of 2007.

Eligibility for Continuation Coverage

Under federal law for employers with 20 or more employees and under M.G.L. c. 176J, § 9 for employer groups with between 2 and 19 employees, 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 ceas[es] to be a dependent child under the generally applicable requirements of the health benefit plan.” For the purpose of the right to continue coverage as a dependent, the date of the qualifying event will be the earlier of the child's 26th birthday or the date two years after the end of the calendar year in which such person last qualified as a dependent under 26 U.S.C. 106, whichever occurs first. If a 22-year old child last qualified as a dependent under IRC 106 on December 31, 2008, her qualifying event date for purposes of COBRA or mini-COBRA would be December 31, 2010, the last day she would be guaranteed eligible under her parent's insured health coverage.

[1] The Division's prior Bulletin 2007-01, Amendments Created by Chapters 58 of the Acts of 2006, as amended, Related to Eligibility as a Dependent in an Insured Health Plan, informed carriers that, effective January 1, 2007, carriers with insured health plans that provide for dependent coverage must make coverage available for persons “under 26 years of age or for 2 years following loss of dependent status under the Internal Revenue Code, whichever occurs first”.

[2] See M.G.L. c. 175, § 108(2)(a)(3); M.G.L. c. 175, § 110(P); M.G.L. c. 176A, § 8BB; M.G.L. c.176B, § 4BB; and M.G.L. c. 176G, § 4T.

[3] Section 106 of the IRC defines “dependent” for purposes of the exclusion from gross income for employer-provided health insurance benefits and is broader than the definition under section 152 of the IRC for purposes of claiming the dependency exemption for the child on the parent's federal income tax return. Therefore, an individual may qualify as a dependent for purposes of the exclusion from gross income for employer-provided health insurance benefits regardless of whether the parent actually claims the dependency exemption for the child on the parent's federal income tax return.

If there are any questions regarding this bulletin, please contact the Division of Insurance at (617) 521-7794.

Any questions regarding the tax implications of the dependent coverage requirements may be directed to the Department of Revenue at (617) 626-3250. Also, please refer to the Department of Revenue's Technical Information Release 07-16, which can be viewed on its website at www.mass.gov/dor, and to the Internal Revenue Service Notice 2004-79.

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NONNIE S. BURNES
COMMISSIONER OF INSURANCE

Bulletin 2007-04

TO: **Insurers Offering Insured Health Products in Massachusetts, Blue Cross and Blue Shield of Massachusetts, and Health Maintenance Organizations**

FROM: Nonnie S. Burnes, Commissioner of Insurance

DATE: **April 11, 2007**

RE: **Non-discriminatory Offer and Equal Contribution by Employers of Insured Group Health Benefit Plan Contracts Pursuant to Chapter 58 of the Acts of 2006, as amended**

This bulletin is intended to summarize and clarify certain provisions related to the non-discriminatory offer and equal contribution by employers of insured group health benefit plan contracts as required by the enactment of Chapter 58 of the Acts of 2006, "An Act Providing Access to Affordable, Quality, Accountable Health Care" (the "Act"), as amended by Chapter 324 of the Acts of 2006 and Chapter 450 of the Acts of 2006. Carriers are to be in compliance with the relevant statutory requirements of M.G.L. c. 175, § 110(O); c. 176A, § 81/2; c. 176B, § 3B; and c. 176G, § 6A; by July 1, 2007, in accordance with the Act.

Collectively, these provisions require that, beginning July 1, 2007, a health carrier is only permitted to enter into an insured group health benefit plan contract with an employer if:

(1) the employer offers the health benefit plan to all of its full-time employees living in Massachusetts; and
(2) the employer does not make a smaller premium contribution percentage to a full-time employee living in Massachusetts than the employer makes to any other full-time employee living in Massachusetts who receives an equal or greater total hourly or annual salary for each specific or general blanket insured group health benefit plan contract. It is noted that this provision does not apply for an employer that establishes separate contribution percentages for employees covered by collective bargaining agreements.

The Division of Insurance would consider the following permissible for health carriers meeting the above referenced statutory requirements:

1. A health carrier can only enter into an insured group health benefit plan contract with an employer that offers that same insured group health benefit plan to all of such employer's full-time employees living in Massachusetts in the health plan's approved service area. Employers are not required to offer the insured group health benefit plan contract to retirees, part-time, temporary or seasonal employees. For purposes of these requirements, the terms "full-time employee" and "part-time, temporary or seasonal employee" will be consistent with provisions within regulations promulgated by the Division of Health Care Finance and Policy (DHCFP) regarding the so-called "employer fair share contribution." Consistent with the DHCFP standards, the Division of Insurance considers that a full-time employee is an employee who is scheduled or expected to work at least the equivalent of an average of 35 hours per week over the applicable base period and who is not a temporary employee (expected to work 12 consecutive weeks or fewer) or a seasonal employee (as so recognized by the Department of Unemployment Assistance).

2. A health carrier can only enter into an insured group health benefit plan contract with an employer that does not discriminate against lower paid full-time employees living in Massachusetts in establishing contribution percentage amounts when contracting for the purchase of an insured group health benefit plan contract for its full-time employees living in Massachusetts. The Division of Insurance considers the following to satisfy the statutory requirements of M.G.L. c. 175, § 110(O); c. 176A, § 81/2; c. 176B, § 3B; and c. 176G, § 6A:

    a. Employers that establish a fixed dollar amount contribution to premium regardless of salary for all full-time employees living in Massachusetts;
    b. Employers that establish different percentage contributions or fixed dollar contributions for different plan choices, whether fully insured or self-funded, as long as the contributions made with respect to each plan on behalf of full-time employees living in Massachusetts do not differ based on the salary level of the full-time employees living in Massachusetts;
    c. Employers that establish greater contribution levels for increasing lengths of service, as long as the schedule of contribution levels is part of a formal employee benefit plan and is designed as a reward for longevity rather than as a pretext for providing better health insurance contributions to more highly paid employees;
    d. Employers that establish greater contributions levels for employees who participate in company-sponsored health and wellness programs would be considered to satisfy the statutory requirements; and
    e. Employers that establish contribution levels for dependents of covered full-time employees living in Massachusetts that differ from the contribution levels for full-time employees would be considered to satisfy the statutory requirements provided that the contribution level is the same for all

dependents of said full-time employees living in Massachusetts and does not differ based on the salary level of the corresponding full-time employees.

3. A health carrier offering insured group health benefit plans through the Connector may rely on the Connector or any of its contracted sub-connectors to verify that employers whose employees are purchasing coverage through the Connector are in compliance with the noted statutory requirements.

4. The carrier's obligation regarding contracting with qualified employers applies at the time the insured health benefit contract is (1) entered into or (2) renewed. A health carrier is not responsible for actively monitoring whether employers' practices change during a contract period.

5. The requirements of this section apply to all insured group health benefit plan contracts that health carriers may enter into with employers on or after July 1, 2007. Any contracts that health carriers enter into prior to July 1, 2007 that go into effect on or after that date are not subject to these provisions.

If there are any questions regarding this bulletin, please contact Nancy Schwartz, Director of the Bureau of Managed Care at (617) 521-7347 or Kevin Beagan, Director of the State Rating Bureau at (617) 521-7323.

Technical Information Release from Mass. Department of Revenue – Finalized December 21, 2007

TIR 07-16: Personal Income Tax Treatment of Employer-Provided Health Insurance Coverage for an Employee's Child

Introduction

The Massachusetts Health Care Reform Act at chapter 58 of the Acts of 2006, as amended, changed chapters 32A, 175, 176A, 176B and 176G of the General Laws to require a broadening of dependent coverage offered by health insurance carriers. The Legislature made several technical corrections to the health care reform law in the recent "Act further Regulating Health Care Access," St. 2007, c. 205, signed into law on November 29, 2007. Collectively, the amendments require that on or after January 1, 2008, carriers issuing or renewing insured health benefit plans with coverage for dependents make coverage available for persons "under 26 years of age or for 2 years after the end of the calendar year in which such persons last qualified as dependents under 26 U.S.C. 106, whichever occurs first." [1]

A noncash fringe benefit that is included in gross income is sometimes referred to as "imputed income." Under federal income tax law, extending employer-provided health insurance coverage to an employee's child up until age 26 may create imputed income for the employee. This TIR provides a summary of Internal Revenue Service Notice 2004-79, a federal notice that provides relief from imputed income in many instances where employer-provided health coverage includes an employee's grown child. Although this TIR provides general guidance, an employer or an employee seeking a case-specific determination on federal imputed income must contact the Internal Revenue Service.

The recent legislation provides an exemption for imputed income for Massachusetts personal income tax purposes where health care coverage is required by Massachusetts law. *See* G.L. c. 62, § 2(a)(2)(Q), as added by St. 2007, c. 205, § 6. As a result, Massachusetts will not follow federal law in the area of imputed income resulting from employer-provided health care fringe benefits.

Federal Income Tax

Section 61(a)(1) of the Code states that, except as otherwise provided, gross income includes compensation for services, including fees, commissions, fringe benefits, and similar items. A fringe benefit is any property or service that an employee receives in lieu of or in addition to regular taxable wages. The extent to which a particular fringe benefit is excluded from gross income depends on the Code provisions that apply to the benefit. A noncash fringe benefit that is included in gross income is sometimes referred to as "imputed income."

Employer-provided health insurance coverage is a fringe benefit. Section 106(a) of the Code provides that gross income of an employee does not include employer-provided coverage under an accident or health plan. Section 1.106-1 of the U.S. Treasury Regulations provides:

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

Under the definition of dependent at § 152, an individual must be either a “qualifying child” dependent or a “qualifying relative” dependent. In general, § 152(c) provides that a “qualifying child” is a child who lives with an employee for more than half a year, who is either under age 19 or is a full-time student under age 24, and who does not provide over half of his or her own support for the calendar year.[2] Section 152(d)(1) provides, in general, that a “qualifying relative” is an individual who bears a relationship to the taxpayer (including any child of the taxpayer who is not a “qualifying child”, regardless of the child’s age), whose gross income is less than the exemption amount ($3,400 in 2007), and who receives over one-half of his or her support from the taxpayer. However, for purposes of the exclusion at § 106 for employer-provided health coverage, an Internal Revenue Service notice expands the definition of dependent at § 152 to eliminate the gross income limit at § 152(d)(1) for a qualifying relative.

In Notice 2004-79, 2004-2, C.B. 898, the Internal Revenue Service announced that U.S. Treasury Regulation § 1.106-1 would be amended effective for taxable years beginning after December 31, 2004 to reflect the same definition for the term dependent in § 105(b) as shown below in bold:

105(b) Amounts expended for medical care. Except in the case of amounts attributable to (and not in excess of) deductions allowed under section 213 (relating to medical, etc., expenses) for any prior taxable year, gross income does not include amounts referred to in subsection (a) if such amounts are paid, directly or indirectly, to the taxpayer to reimburse the taxpayer for expenses incurred by him for the medical care (as defined in section 213(d) of the taxpayer, his spouse, and his **dependents (as defined in section 152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof). Any child to whom section 152(e) applies shall be treated as a dependent of both parents for purposes of this subsection.[3]**

Accordingly, under Internal Revenue Service Notice 2004-79, an employee may exclude from gross income the value of employer-provided health insurance coverage for a child who, while not a “qualifying child,” meets the definition of a “qualifying relative” determined without regard to the child’s gross income. In effect, many children who do not meet the age requirements of a “qualifying child” will meet the requirements of a “qualifying relative” where the income limitation of $3,400 (for 2007) is not applied. For purposes of the exclusion from gross income at § 106 for employer-provided health insurance coverage, a child of an employee who exceeds the age to be a “qualifying child” is a "qualifying relative” if the taxpayer provides over half of the child’s support for the calendar year; also, any child of divorced parents who meets the expanded definition of dependent in connection with one parent is treated as a dependent of both parents. In such a case, the child is considered a dependent for purposes of § 106 and there is no federal imputed income charged to the employee.

Valuation of Imputed Income is a Question of Federal Law. As a result of extended employer-provided health insurance coverage for children “under 26 years of age or for 2 years after the end of the calendar year in which such persons last qualified as dependents under 26 U.S.C. 106, whichever occurs first,” there will be some instances where the benefits provided to an employee include health insurance for a nondependent child for purposes of IRC § 106 (*e.g.*, a child that is over the age to be a “qualifying child” *and* is not a “qualifying relative” because the child provides at least half of his or her own support). For federal income tax purposes, an employee who opts for coverage for a nondependent child will be taxed on the fair market value of the child’s coverage to the extent that it

exceeds any amount paid by the employee on an after-tax basis (employee pre-tax contributions are considered to be employer contributions). Pending specific guidance from the Internal Revenue Service, an employer must determine the amount of imputed income attributable to the health insurance coverage of an employee's nondependent child under valuation principles articulated in federal income tax law.

MassachusettsPersonal Income Tax.

Effective for taxable years beginning on or after January 1, 2007, General Laws chapter 62,§ 2(a)(2)(Q) provides that the following item must be deducted from Massachusetts gross income:

If an employee participates in an employer-provided health insurance plan, any amount which, but for this section, would be included in gross income of the employee by reason of coverage under the plan of any person other than the employee, to the extent such coverage is mandated by law.

Massachusetts gross income is federal gross income, as defined under the Code, with certain modifications. G.L. c. 62, § 2(a). Generally, with respect to the personal income tax, Massachusetts adopts the Code as amended and in effect on January 1, 2005. G.L. c. 62, § 1. Massachusetts follows IRC § 106 as amended and in effect of January 1, 2005, whereby employer-provided health and accident premiums are excluded from the gross income of an employee, as long as the benefits are for the employee, the spouse or dependents of the employee. Also, Massachusetts adopts IRS Notice 2004-79 which expands the definition of dependent for purposes of the exclusion from gross income at IRC § 106.

As a result, the value of employer-paid health insurance benefits for a child of an employee who is a dependent under the federal income tax rules at IRC § 106 is excluded from the employee's federal gross income and is likewise excluded from the employee's Massachusetts gross income. However, pursuant to G.L. c. 62, § 2(a)(2)(Q), any imputed income resulting from health insurance coverage for an employee's child who is not a dependent under IRC § 106 that is included in an employee's federal gross income is excluded from Massachusetts gross income to the extent such coverage is mandated by Massachusetts law. The exclusion from Massachusetts gross income under G.L. c. 62, § 2(a)(2)(Q) also applies to employees with coverage under self-funded or self-insured employer-provided health plans adopting dependent health coverage otherwise required for insured plans under the applicable Massachusetts insurance statutes.

/s/ Henry Dormitzer
Henry Dormitzer
Commissioner of Revenue

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TIR 07-16
December 21, 2007

Appendix to TIR 07-16

Personal Income Tax Treatment of Employer-Provided Health Insurance Coverage for an Employee's Child under the Massachusetts Health Care Reform Law

As of January 1, 2008, the Massachusetts Health Care Reform Act expands employer-provided health insurance coverage to include an employee's child "under 26 years of age or for 2 years after the end of the calendar year in which such persons last qualified as dependents under 26 U.S.C. 106, whichever occurs first."[4] The reference to 26 U.S.C. 106 is section 106 of the Internal Revenue Code.

Recent legislation provides for the exclusion from Massachusetts gross income of any imputed income resulting from employer-provided health insurance of a person included in the employee's family health insurance plan where the coverage is required by state law. *See* G.L. c. 62, § 2(a)(2)(Q).

The purpose of this fact sheet is to provide general guidance on the federal and Massachusetts treatment of employer-provided health insurance coverage for an employee's child. As explained in TIR 07-16, whether a child of an employee is a dependent for purposes of the federal exclusion from gross income of employer-provided health insurance coverage is a question of federal income tax law pursuant to Internal Revenue Code section 106. An employer or an employee seeking a case-specific determination on imputed income for federal income tax purposes must contact the Internal Revenue Service.

A. What is imputed income?

The term "imputed income" is sometimes used to refer to the value of a noncash fringe benefit an employee receives where federal law requires the value of the fringe benefit to be included in the employee's gross income.

In the area of employer-provided health insurance coverage (which is a fringe benefit), the value of health insurance benefits for a child of an employee is excluded from gross income where the child is a dependent under the rules of IRC section 106. However, for federal income tax purposes, the value of health insurance benefits for a child of an employee is treated as imputed income in cases where the child does not qualify as a dependent under IRC section 106. This can happen, for example, when the child is over age 24 or is emancipated.

If a child does not meet the definition of dependent for these purposes, the value of the health coverage for this individual will be imputed as income to the employee for federal income tax purposes. The employee's federal gross income for the year, as reflected in his or her W-2, will be higher and this higher amount will be subject to taxation and withholding.

Although generally Massachusetts follows federal law in the area of noncash fringe benefits, in the case of imputed income with respect to employer-provided health insurance, the Legislature has chosen to depart from the federal treatment. Where an employee is charged with federal imputed income for employer-provided health coverage, the employee is not charged with the imputed income for Massachusetts purposes where the health care coverage is required by state law. For an affected employee, the Massachusetts gross income for the year, as reflected in his or her W-2, will be lower than federal gross income.

B. When does an employee's child meet the definition of dependent for purposes of employer-provided health insurance coverage so that the entire value of the coverage is excluded from gross income?

Under federal tax law, employer contributions for health insurance are excluded from an employee's gross income. However, the exclusion is limited to contributions made for coverage of the employee, the employee's spouse, and the employee's dependents.

In general, for a child to be considered a dependent under the Internal Revenue Code, the child must meet the requirements of a "qualifying child" or a "qualifying relative" as described below. Pursuant to IRS Notice 2004-79, the definition of "dependent" for purposes of the exclusion from gross income for employer-provided health insurance benefits is broader than the definition for purposes of claiming the dependency exemption for the child on the parent's federal income tax return. So achild may qualify as a dependent for purposes of the exclusion from gross income for employer-provided health insurance benefits whether or not the parent actually claims the dependency exemption for the child on the parent's federal income tax return.

Divorced Parents. For purposes of the exclusion from gross income for employer-provided health insurance, any child of divorced parents who meets the expanded definition of dependent in connection with one parent is treated as a dependent of both parents.

- **Qualifying Child (Age Requirement):**

1. *Relationship*: The child must be the taxpayer's son, daughter, stepchild, sibling or stepsibling. A descendant of any of the above also qualifies (*e.g.*, taxpayer's grandchild). A legally adopted child or a child lawfully placed with the taxpayer for adoption is treated as a taxpayer's child. A foster child legally placed with the taxpayer is also treated as the taxpayer's child.
2. *Residency*: The child must have the same principal place of abode as the taxpayer for more than half of the taxable year. Temporary absences because of special circumstances, including illness, education, business, vacation or military service, do not prevent the child from qualifying.
3. *Age*: In general, the child must be under age 19 (or under age 24 if a full-time student) as of the end of the calendar year. In the case of an individual who is permanently and totally disabled, the age limits are waived.
4. *Support*: The child must not have provided more than half of his or her support for the year.

If a taxpayer's child does not meet the requirements of a dependent as a "qualifying child," the child may still meet the requirements of a dependent as a "qualifying relative."

- **Qualifying Relative (No Age Requirement):**

1. *Support:* The child must have received over half of his or her support from the taxpayer for the calendar year. In contrast to the rules for a qualifying child (see above), there is no residency requirement for a taxpayer's child to meet the definition of a qualifying relative.[5]

2. *Income limits:* Under IRS Notice 2004-79, for purposes of determining whether there is an exclusion from gross income for employer-provided health care benefits, there is no limit on the child's gross income. (By contrast, for purposes of determining whether a child is a "qualifying relative" for the dependency exemption, the child's gross income must not exceed the exemption amount of $3,400 for 2007.)

C. When does employer-provided health insurance coverage for an employee's child result in imputed income to the employee?

In the context of employer-provided health insurance benefits, the following examples illustrate when imputed income occurs and when it does not.

Example 1. A child, age 25, who earns $10,000 receives over half of her support from her mother and is included in the mother's employer-provided health insurance coverage.

- The child is considered a dependent for purposes of the income exclusion for employer-provided health insurance coverage. Under IRS Notice 2004-79, the child is a "qualifying relative" because, (1) the child receives over half of her support from her mother, and (2) for purposes of the exclusion from gross income for employer-provided health insurance, the amount of the child's earnings is disregarded. As a result, there is no imputed income to the mother for federal or Massachusetts purposes.
- However, the mother is not allowed to claim either a federal or a Massachusetts dependency exemption for the child. The child is not a "qualifying child" because the child's age exceeds the maximum age. Also, the child is not a "qualifying relative" for purposes of the dependency exemption because the child's earnings exceed the exemption amount ($3,400 in 2007).

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

- The child is considered a dependent for purposes of the income exclusion for employer-provided health insurance coverage. Under IRS Notice 2004-79, the child is a "qualifying relative" because the child is supported by his parents. For both federal and Massachusetts purposes, there is no imputed income to the father as a result of the employer-provided health insurance coverage of the child.
- Because of the terms of the divorce agreement, the father does not take a dependency exemption for the child. However, the mother is entitled to take the federal dependency exemption for the child. The child is not a "qualifying child" because the child's age exceeds the maximum age. However, the child is a "qualifying relative" for purposes of the dependency exemption because the child has no earnings. If applicable, the mother is entitled to take the Massachusetts dependency exemption for the child.

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

- The employer's carrier is required to make coverage available for this child for two years after the end of the calendar year in which such person last qualified as a dependent under IRC § 106 or until the child reaches 26 years of age, whichever occurs first.
- The child is not considered a dependent for purposes of the income exclusion for employer-provided health insurance coverage. The child does not come within the requirements of IRS Notice 2004-79 because the child does not receive over half of his or her support from the parent. Thus, for federal purposes, the value of health insurance coverage for the age-25 child will be imputed income to the employee. In contrast, under G.L. c. 62, § 2(a)(2)(Q), Massachusetts does not impose tax on this imputed income because the coverage is required by state law.
- The parent is not allowed to claim a federal or Massachusetts dependency exemption for the child. The child is not a "qualifying child" because the child's age exceeds the maximum age; the child is not a "qualifying relative" because (1) the child does not receive over half of his or her support from the parent, and (2) the child's earnings exceed the exemption amount of $3,400 in 2007.

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[1] The reference to 26 U.S.C. 106 is section 106 of the Internal Revenue Code. Also, prior to the clarification in the technical corrections Act, the health care reform law required that on or after January 1, 2007, carriers issuing or renewing insured health benefit plans with coverage for dependents make coverage available for persons "under 26 years of age or for 2 years following loss of dependent status under the Internal Revenue Code, whichever occurs first."

[2]If a child of a taxpayer is a "qualifying child," there will be no imputed income resulting from employer-provided health insurance coverage. This TIR focuses on the instances where a child of a taxpayer who is not a "qualifying child" may be a "qualifying relative." Whether such children meet the requirements of "qualifying relative" is the determining factor as to whether the employee is charged with imputed income.

[3] Section 152(e) contains the special rules for divorced parents.

[4] Prior to the clarification in the technical corrections Act at St. 2007, c. 205, the health care reform law required that on or after January 1, 2007, carriers issuing or renewing insured health benefit plans with coverage for dependents make coverage available for persons "under 26 years of age or for 2 years following loss of dependent status under the Internal Revenue Code, whichever occurs first."

[5]For purposes of the qualifying relative definition, if a person does **not** have a "relationship" with the taxpayer as defined in section 152(d) of the Internal Revenue Code (*e.g.*, child, brother, sister, father, mother, etc.), there is a residency requirement; a qualifying relative also includes an individual (other than an individual who at any time during the taxable year was a spouse) who has the same principal place of abode as the taxpayer and is a member of the taxpayer's household.

Section 9
Commonwealth Choice

Fact Sheet: Commonwealth Choice

Commonwealth Choice

What is Commonwealth Choice?

Commonwealth Choice is a program offered through the Commonwealth Health Insurance Connector Authority (the Connector) that is designed to "connect" individuals and small employers to health insurance. Coverage under Commonwealth Choice is through private health insurance plans that have received the Connector's Seal of Approval.

Who is eligible for Commonwealth Choice?

Generally, Massachusetts residents without access to health insurance offered through an employer may enroll in Commonwealth Choice.

Employees with access to group coverage are eligible if:

- Their employer does not offer to contribute at least 33% of the individual premium or 20% of the family premium; or
- They work for an employer of 50 or fewer employees regardless of the employer's premium contribution amount; or
- The employer-sponsored coverage does not comply with minimum creditable coverage standards.

Small employers (up to 50 employees) have the option of providing insurance to their employees under Commonwealth Choice through a group concept developed by the Connector.

What is the cost for Commonwealth Choice?

Commonwealth Choice is not a subsidized program. The monthly premium will depend upon the carrier and benefit package chosen by the individual or employer. In addition to the monthly premium, copayments and deductibles may apply and will also vary based on the insurance plan that is selected.

How are premiums paid for Commonwealth Choice plans?

Individual purchasers who are not employed or who do not have access to a Section 125 plan through their employer will be billed directly by the Connector. Those who have access to a Section 125 plan through their employer, and who choose to do so, may be able to pay their premiums on a pre-tax basis according to the rules set forth in their employer's plan document.

How are pre-tax premium payments processed?

Employers may establish an account with the Connector through which employee enrollments and pre-tax payments are handled. (For detailed information, contact the Connector directly.) As an alternative, employers may require that employees pay the premium and submit proof of payment in order to receive reimbursement from funds deferred through their Section 125 election.

In all cases, employers must administer pre-tax premium payments as described in their specific Section 125 plan documents.

How do individuals enroll in Commonwealth Choice?

Toll-free phone: 877-MA-ENROLL (1-877-623-6765) (TTY: 1-877-623-7773) during the hours of 8:00 a.m. to 5:00 p.m., Monday through Friday, or through an excellent web site: www.mahealthconnector.org.

Section 10
Commonwealth Care

Fact Sheet: Commonwealth Care

Final Regulations – Eligibility and Hearing Process for Commonwealth Care

Fact Sheet

The Massachusetts Health Care Reform Law

Commonwealth Care

Status of Regulations	Final
Administrative Agency:	The Connector
Effective Date:	June 26, 2009

What is Commonwealth Care?

Commonwealth Care is a state-subsidized health insurance program offered through the Connector for residents of MA who are age 19 or older and whose income is at or below 300% of the Federal Poverty Level (FPL).

Individuals are not eligible for Commonwealth Care if they have waived employer-subsidized insurance within 6 months or if they have accepted a payment in lieu of employer-sponsored insurance benefits.

Individuals may be eligible for Commonwealth Care if their employer offered coverage but did not offer to contribute at least 33% toward the cost of individual coverage or 20% toward the cost of family coverage.

What is the cost of Commonwealth Care?

For individuals with income up to150% FPL, the monthly premium is fully paid by the state. Individuals with incomes between 151% and 300% FPL are charged on a sliding scale basis. Applicable charges are determined by the Connector and are subject to review/revision annually.

How are premium payments sent to the Connector?

Participants are invoiced directly by the Connector. Pre-tax premium payments for Commonwealth Care are currently not available.

How do individuals enroll in Commonwealth Care?

Connector customer service representatives are available to help determine eligibility for Commonwealth Care, Commonwealth Choice and MassHealth. They can be reached toll-free from 8:00 a.m. to 5:00 p.m. Monday through Friday at 1-877-MA-ENROLL (1-877-623-6765) (TTY: 1-877-623-7773).

956 CMR 3.00 Eligibility and Hearing Process for Commonwealth Care

Section 3.01 Authority

956 CMR 3.00 is promulgated in accordance with the authority granted to the Connector by M.G.L. c. 176Q.

Section 3.02 Purpose

The purpose of 956 CMR 3.00 is to implement the provisions of M.G.L. chs. 118H and 176Q and thereby facilitate the availability, choice and adoption of private health benefit plans to eligible individuals and groups.

Section 3.03 Scope

956 CMR 3.00 contains the Connector's regulations governing eligibility for participation in Commonwealth Care, enrollment, responsibility of Enrollees, Enrollee premium contributions, disenrollment and the related fair hearing process under M.G.L. chs. 118H and 176Q. The Connector also promulgates other regulations, and publishes other documents affecting its programs, including statements of policy and procedure, conditions of participation, guidelines, billing instructions, administrative information bulletins and other documents as necessary.

Section 3.04 Definitions

As used in 956 CMR 3.00, the following terms shall mean:

Abuse – Physical or verbal abuse which poses a threat to health care providers or other insureds of the Health Plan and which is unrelated to the Enrollee's physical or mental condition.

Adverse Eligibility Determination—a determination that an applicant is not eligible to participate in Commonwealth Care or a determination that an Enrollee is no longer eligible to participate in Commonwealth Care.

Appeal Representative – a person who:

(a) is sufficiently aware of an appellant's circumstances to assume responsibility for the accuracy of the statements made during the appeal process, and who has been provided with written authorization from the appellant to act on the appellant's behalf during the appeal process;
(b) has, under applicable law, authority to act on behalf of an appellant in making decisions related to health care or payment for health care. An appeal representative may include, but is not limited to, a guardian, conservator, executor, administrator, holder of power of attorney or health care proxy.

Appealable Action—any of the actions listed in 956 CMR 3.14.

Applicant – a person who completes and submits an application for Commonwealth Care.

Application - a form prescribed by the Connector to be completed by the applicant or a representative, and submitted to the Connector or its designee as a request for a determination that the Applicant is eligible for enrollment in Commonwealth Care.

Board- the Board of the Commonwealth Health Insurance Connector Authority, established by M.G.L. c. 176Q, §2.

Commonwealth. The Commonwealth of Massachusetts

Commonwealth Care Health Insurance Program or Commonwealth Care- the programs administered by the Authority pursuant to M.G.L. c. 118 H and other applicable laws to furnish and to pay for health benefit plans for Eligible Individuals.

Commonwealth Care Rules and Regulations – all regulations, bulletins and other written directives duly adopted or issued by the Connector relating to the Commonwealth Care program.

Commonwealth Health Insurance Connector Authority or Connector or Authority- the entity established pursuant to M.G.L. c. 176Q, § 2.

Co-payment- a fixed amount paid by an Enrollee for applicable services or for prescription medications at the time they are provided.

Covered Services- the range of medical services required to be provided by a Health Plan under Commonwealth Care.

Day- a calendar day unless a business day is specified.

Eligible Individual- an individual who is a resident of the Commonwealth and who is eligible to participate in Commonwealth Care in accordance with M.G.L. c. 118H and 956 CMR 3.09.

Eligibility Process- activities conducted by the Connector or its designee for the purposes of determining, redetermining and maintaining the eligibility of Eligible Individuals for Commonwealth Care participation.

Enrollee- an Eligible Individual enrolled by the Connector or its designee in a Health Plan, either by choice or assignment.

Enrollment—the selection of a Health Plan, either by choice of the Eligible Individual or by assignment.

Enrollment Effective Date—the first day of the calendar month following the completion of the Enrollment Process.

Enrollment Process—the process in which an Eligible Individual chooses a Health Plan, or is assigned to a Health Plan by the Connector.

Family – persons who live together, and consists of:

(a) two persons who are married to each other and have no children under the age of 19 living with them;
(b) a child or children under age 19, any of their children, and their parent(s);
(c) siblings under age 19 and any of their children who live together even if no adult parent or caretaker relative is living in the home; or
(d) a child or children under age 19, any of their children, and their caretaker relative when no parent is living in the home. A caretaker relative may choose whether or not to be part of the family. A parent may choose whether or not to be included as part of the family of a child under age 19 only if that child is:

1) pregnant; or
2) a parent.

A child who is absent from the home to attend school is considered as living in the home. A parent may be a natural, step, or adoptive parent. Two parents are members of the same family group as long as they are both mutually responsible for one or more children who live with them.

Fair Hearing – an administrative, adjudicatory proceeding pursuant to 130 CMR 610.000 to determine the legal rights, duties, benefits or privileges of Applicants and Enrollees pertaining to

initial eligibility determinations, eligibility reviews, and certain other determinations by MassHealth.

Federal Poverty Level (FPL)- the income standard, by such name, issued annually in the *Federal Register*, as adjusted to account for the last calendar year's increase in prices as measured by the Consumer Price Index.

Fraud – An intentional deception or misrepresentation made by a person or corporation with the knowledge that the deception could result in some unauthorized benefit under the Commonwealth Care program to himself, the corporation, or some other person. It also includes any act that constitutes fraud under applicable Federal or state health care fraud laws. Examples of Enrollee fraud include, but are not limited to: improperly obtaining prescriptions for controlled substances and card sharing.

Gross Income – the total money earned or unearned, such as wages, salaries, rents, pensions, or interest, received from any source without regard to deductions.

Health Plan—any managed care organization or carrier that is contracted with the Connector to provide covered services to Commonwealth Care Enrollees.

Hearing—an administrative, adjudicatory proceeding pursuant to 801 CMR 1.02 to determine the legal rights, duties, benefits or privileges of Applicants (in certain, limited circumstances) and Enrollees pertaining to enrollment and plan assignments, disenrollments of Enrollees for failure to pay, disenrollments of Enrollees based upon the discretion of the Connector; Enrollee Premium Contributions and co-payment maximum limits; and denials of waiver requests.

Non-premium-paying Plan Type-- A Plan Type for which an Enrollee is not required to pay an Enrollee Premium Contribution under the Premium schedule established by the Board pursuant to 956 CMR 3.12(8). In the event that one Plan Type includes both premium-paying and non-premium-paying Enrollees depending on the Enrollees' income, regulations applicable to non-premium-paying Plan Types will apply only to the Enrollees in the Plan Type who are not required to pay Enrollee Premium Contributions.

Plan Type – a type of coverage for Enrollees with income within a certain range.

Premium Assistance Payment- a periodic payment made to a Health Plan by the Commonwealth or the Connector on behalf of an Enrollee from funds appropriated by the Commonwealth or other funds made available to the Connector for such purpose.

Premium Contribution or Enrollee Premium Contribution-- an Enrollee's actual required periodic financial contribution for coverage under Commonwealth Care, determined in accordance with applicable regulations of the Connector, paid to the Connector.

Resident- a person living in the Commonwealth, as defined by the office of Medicaid by regulation, including a qualified alien, as defined by section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, or a person who is not a

citizen of the United States but who is otherwise permanently residing in the United States under color of law as defined by the office of Medicaid by regulation; provided, however, that the person has not moved into the Commonwealth for the sole purpose of securing health insurance under M.G.L. c. 118H; and provided, further, that confinement of a person in a nursing home, hospital or other medical institution in the Commonwealth shall not, in and of itself, suffice to qualify a person as a resident.

Service Areas – the Authority's grouping of the cities and towns within the Commonwealth into distinct areas for Commonwealth Care, as established by contract with the Contracted MMCO.

Section 3.05 Eligibility for Commonwealth Care

(1) Eligibility for Commonwealth Care is determined by the Commonwealth's Office of Medicaid, under authorization of the Connector and consistent with the Connector's regulations regarding eligibility. The eligibility determination includes a determination of both

(a) whether, based on individual or family household income, the individual is financially eligible for Commonwealth Care and

(b) whether the individual meets other eligibility requirements, including residence and uninsured status, as set forth in 956 CMR § 3.04 and 3.09.

(2) The Office of Medicaid will use the same methods as are used for MassHealth to determine individual or family household income level and Resident status. The financial eligibility for various Commonwealth Care Plan Types is determined by comparing the individual or family group's monthly Gross Income with the applicable income standard for the specific Coverage Type. In determining monthly Gross Income, the Office of Medicaid multiplies average weekly income by 4.333.

(3) Included in the financial eligibility determination will be a determination of the Plan Type to which an Eligible Individual should belong based on individual or family household income. Covered Services, Premium Contributions and Co-Payments will vary among Plan Types, as determined by the Board. The following are the different levels of such income for each Plan Type:

(a) Plan Type I- not in excess of 100% of Federal Poverty Level.

(b) Plan Type II- more than 100% but not in excess of 200% of Federal Poverty Level, except that persons below 150% of Federal Poverty Level will be in Plan Type IIA, and those between 150% and 200% of Federal Poverty Level will be in Plan Type IIB.

(c) Plan Type III - more than 200% but not in excess of 300% of Federal Poverty Level..

(4) The monthly Federal Poverty Level income standards are determined according to annual standards published in the Federal Register using the formula set forth in 956 CMR 3.05(4)(a) through (c). The Connector adjusts these standards in April of each calendar year or such earlier date as may be determined.

(a) Divide the annual Federal Poverty Level income standard as it appears in the Federal Register by 12.
(b) Multiply the unrounded monthly income standard by the applicable Federal Poverty Level standard.
(c) Round up to the next whole dollar to arrive at the monthly income standards.

Section 3.06 Matching Information

The Connector or its designee initiates information matches with other agencies and information sources when an Application is received, when eligibility is redetermined, or at other times in the Connector's administrative processes in order to verify eligibility or certain information. These agencies and information sources may include, but are not limited to, the following: the Division of Unemployment Assistance, MassHealth, Department of Public Health's Bureau of Vital Statistics, Department of Industrial Accidents, Department of Veteran's Services, Department of Revenue, Bureau of Special Investigations, Internal Revenue Service, Social Security Administration, Alien Verification Information System, Department of Transitional Assistance and health insurance carriers.

Section 3.07 Time Standards for an Eligibility Determination

In making an eligibility determination for Commonwealth Care, the Office of Medicaid will require an applicant to complete an application and provide the information requested in that application. Based on the information supplied in that application, additional information may be requested to determine eligibility status. The eligibility determination will be made within 45 days from the date of receipt of the information requested during the determination process.

Section 3.08 Eligibility Review

(1) The Connector or its designee may review eligibility every 12 months. Eligibility may also be reviewed more frequently as a result of an Enrollee's change in circumstances, or a change in Commonwealth Care eligibility rules. The Connector or its designee updates the case file based on information received as the result of such review. The Connector reviews eligibility:
    (a) by information matching with other agencies, health insurance carriers, and information sources as set forth in 956 CMR 3.06;
    (b) through a written update of the Enrollee's circumstances on a prescribed form; and
    (c) based on information in the Enrollee's case file.

(2) The Connector determines, as a result of this review, if:
    (a) the Enrollee continues to be eligible for Commonwealth Care; or
    (b) the Enrollee's current circumstances require a change in Plan Type or Premium Contribution.

(3) The Connector or its designee will notify the Enrollee if there is a change in Plan Type or Premium Contribution, or a change in Enrollee's eligibility.

(4) In the event of a determination that the Enrollee is no longer eligible, the Enrollee will be sent a notice of termination at least 14 days before the termination occurs.

Section 3.09 Eligibility Requirements

(1) An uninsured individual who is a resident of the Commonwealth shall be eligible to participate in Commonwealth Care in accordance with M.G.L. c. 118H if:

(a) an individual's or family's household income does not exceed 300 % of the Federal Poverty Level;

(b) the individual is not eligible for any MassHealth program, including the Children's Medical Security Plan (other than emergency care under MassHealth Limited), for Medicare, or for the State Children's Health Insurance Program established by M.G.L. c. 118, § 16C;

(c) unless waived by the Board pursuant to M.G.L. c. 118H, § 3(b), the individual's or family member's current employer has not provided health insurance coverage in the last six months for which the individual is eligible and for which the employer covers at least 20% of the annual premium cost of a family health insurance plan or at least 33% of an individual health insurance plan; and

(d) the individual has not accepted a financial incentive from his employers to decline his employer's subsidized health insurance plan.

(2) Persons shall not be deemed uninsured for purposes of determining eligibility for Commonwealth Care if such persons are eligible for other government programs that cover hospitalization and physician services including, but not limited to, one of the following programs:

1. TRICARE, the Department of Defense's managed health care program for active duty military, active duty service families, retirees and their families, and other beneficiaries, established pursuant to 10 U.S.C. § 1073;
2. Massachusetts Fishermen's Partnership, Inc.'s health insurance program, funded, in part, pursuant to St. 2006, c. 58, § 102 and in accordance with M.G.L. c. 118G, § 18;
3. student health insurance programs available to full-time or part-time students enrolled in a public or independent institution of higher learning located in the Commonwealth pursuant to M.G.L. c. 15A, §18, and

4. The Massachusetts Division of Unemployment Assistance's Medical Security Program, which provides health insurance assistance for residents of the Commonwealth who are receiving unemployment insurance benefits, pursuant to M.G.L. c. 151A.

(3) Persons shall be deemed uninsured for purposes of determining eligibility for Commonwealth Care if:

(a) such persons are insured solely under a health benefit plan for which they pay the full premium obtained pursuant to the Consolidated Omnibus Budget Reconciliation Act ("COBRA") at 29 U.S.C. § 1161 or the Small Group Health Insurance Continuous Coverage Act at M.G.L. c. 176J, § 9 or obtained as an individual in the non-group insurance commercial market; or

(b) if and to the extent such persons are in a waiting period prior to becoming eligible under an employer-provided health benefit plan for which the employer covers at least 20% of the annual premium cost of a family health benefit plan or at least 33% of an individual health benefit plan.

Section 3.10 Responsibilities of Applicants and Enrollees

(1) Responsibility to Cooperate. The Applicant or Enrollee must cooperate with the Connector or its designee in providing information necessary to establish and maintain eligibility and to bill and collect Enrollee Premium Contributions, and must comply with all the rules and regulations of the Connector or its designee. An Applicant's failure to provide information requested during the eligibility determination process may result in a delay in the eligibility determination, or a denial of eligibility.

(2) Responsibility to Report Changes. The Applicant or Enrollee must report to the Connector or its designee, within ten days or as soon as possible, changes that may affect eligibility or Enrollee Premium Contributions. Such changes include, but are not limited to, residency, address, income, employment, the availability of health insurance, and third-party liability.

(3) Third Party Liability. If an Enrollee is involved in an accident or suffers an injury in some manner and subsequently receives money from a third party as a result of that accident or injury, the Connector or the Enrollee's then-current Health Plan may have a right to recover some or all of those funds to repay the Connector or the then-current Health Plan for certain medical services provided to the Enrollee by the Health Plan. In the event that the Connector and/or the Health Plan intend to recover any funds from an Enrollee, the Connector and/or the Health Plan will provide notice to the Enrollee of any obligation to pay funds back.

Section 3.11 Enrollment, Transfer and Disenrollment

(1) Health Plan Selection. Eligible Individuals must enroll in Commonwealth Care by selecting a Health Plan. Health Plan selection will occur by choice of the Eligible Individuals or, as set forth in 956 CMR 3.11(2), by assignment. Eligible Individuals may choose any Health Plan that operates in their Service Area.

(2) Assignment to a Health Plan. If an Eligible Individual who is eligible for Plan Type I does not choose a Health Plan within the time period specified by the Connector in a notice to the Eligible Individual, the Connector may assign that Eligible Individual to a Health Plan. The Connector will assign that individual to the lowest-cost Health Plan available in that individual's Service Area, unless the individual had previously been enrolled in a different Health Plan within a time period determined by the Connector, which shall be no less than 90 days, in which case the individual shall be re-assigned to the same Health Plan. The Connector will assign Eligible Individuals only to Health Plans that operate in the Service Areas where the Eligible Individuals reside.

(3) Enrollment Effective Date. Eligible Individuals must complete the Enrollment Process in order to receive Covered Services. Coverage will begin on the Enrollment Effective Date.

(4) Premium Contributions. Premium Contributions paid by Enrollees within the same Plan Type may vary depending on the Health Plan selected. The differentials in Premium Contributions for Health Plans will be determined by the Connector based on the difference in cost to the Connector of the Health Plans. There will be at least one Health Plan available to Plan Type I and Plan Type IIA members that has no Premium Contribution. There will be at least one Health Plan available to Plan Types IIB and III members that will cost the minimum Premium Contribution set by the Board in the accordance with 956 CMR 3.12(8).

(5) Notification. The Connector will notify an Enrollee in writing of the name and address of the Enrollee's Health Plan and Enrollment Effective Date.

(6) Transfer. The Enrollee may transfer from a Health Plan within 60 days after the Enrollment Effective Date and during any open enrollment periods established by the Connector. Other than those time periods, an Enrollee may transfer from a Health Plan only for one of the following reasons:

a. the Enrollee has moved and the new residential address is outside the Service Area in which the Enrollee's Health Plan operates;
b. the Enrollee demonstrates to the Connector that:
   1. the Enrollee has a medical condition and continued enrollment in the current Health Plan will result in a lack of continuity of care, and
   2. the current Health Plan has not provided the Enrollee with access to health care providers that meet the Enrollee's health care needs over time, even after the Enrollee has asked the Health Plan for help;
c. the Enrollee's primary care provider is no longer a contracted provider with the current Health Plan's network;

d. the Enrollee's health care access has been adversely affected by a significant change in the current Health Plan's network of providers, which may include, without limitation, the loss of a contract with a hospital, health center, physician group or specialty provider group;
e. the Enrollee has an eligibility change in Plan Types;
f. the Enrollee is homeless and that status has been reported to the MassHealth eligibility system; or
g. the enrollment materials sent to the Enrollee were returned without being delivered.

, (7) Disenrollment of Enrollees.

(a) The Connector may disenroll or transfer an Enrollee from a particular Health Plan, upon request of the Health Plan, if the Health Plan has established that the Enrollee has committed Fraud or Abuse.

(b) The Connector may disenroll an Enrollee from Commonwealth Care for failure to pay Enrollee Premium Contribution payments under 956 CMR 3.12.

(c) The Connector may disenroll an Enrollee from Commonwealth Care for Fraud or Abuse.

(d) If the Connector disenrolls an Enrollee pursuant to 956 CMR 3.11(7), it will provide the enrollee with written notice stating the reason for the action.

(8) Re-enrollment. Any Enrollee in a Non-premium-paying Plan Type who loses Commonwealth Care eligibility and then regains eligibility shall be automatically enrolled by the Connector in the lowest-cost Health Plan in that Enrollee's Service Area, unless the Enrollee is re-enrolling after a time period, as determined by the Connector, which shall be no less than 90 days, in which case the Enrollee will be automatically re-enrolled in the Health Plan in which the Enrollee was previously enrolled, if still available. In the case of re-enrollment after disenrollment under 956 CMR 3.11 (7)(a), in which case the Connector may make such automatic re-enrollment as it deems most appropriate.

Section 3.12 Commonwealth Care Enrollee Premium Contributions

(1) Enrollee Premium Contribution Payments. Enrollees who are assessed an Enrollee Premium Contribution are responsible for monthly payments beginning the calendar month of the Enrollment Effective Date. The Connector will establish and maintain at least one convenient payment method for Enrollees.

(2) Delinquent Enrollee Premium Contribution Payments

(a) If the Connector or its designee has billed an Enrollee for a payment, and the Enrollee does not pay all of the amount billed within at least 60 days of the date on the bill, then the Enrollee's coverage under Commonwealth Care is terminated,

except as provided below. The Enrollee will be sent a notice of termination at least 14 days before the date of termination. The Enrollee's coverage will not be terminated if, before the date of termination, the Enrollee:

1. pays at least two months of past due Enrollee Premium Contributions;
2. submits an application for a financial hardship waiver pursuant to 956 CMR 3.12(5); or
3. establishes a payment plan acceptable to the Connector.

(b) After such a payment plan has been established, the Connector will bill the Enrollee for:

1. payments in accordance with the payment plan; and
2. monthly Enrollee Premium Contributions due subsequent to the establishment of the payment plan. If the Enrollee does not make payments in accordance with the payment plan within 30 days of the date on the bill, the Enrollee's eligibility is terminated. If the Enrollee does not pay monthly Enrollee Premium Contributions due subsequent to the establishment of the payment plan within 60 days of the date on the bill, the Enrollee's eligibility is terminated as set forth in the first paragraph of 956 CMR 3.12(2).

(3) Reactivating Coverage Following Disenrollment.

(a) An Eligible Individual who has been disenrolled for failure to pay Enrollee Premium Contributions or for any other reason, other than a disenrollment under 956 CMR § 3.11(7)(c) will be re-enrolled in Commonwealth Care if capacity exists. Prior to re-enrollment, the Eligible Individual must pay in full all payments due unless such overdue amounts have been waived, or establish a payment plan with the Connector. Individuals disenrolled under 956 CMR § 3.11(7)(c) will be re-enrolled at the Connector's discretion.

(b) If no capacity exists in Commonwealth Care, there will be a waiting list for individuals seeking to re-enroll. Re-enrollment will not occur until the Connector is able to reopen enrollment for those placed on the waiting list. When the Connector is able to open enrollment for those on the waiting list, Eligible Individuals on the waiting list will be processed in the order they were placed on the waiting list.

(4) Waiver of Outstanding Enrollee Premium Contribution Payments.
If an Enrollee whose eligibility has been terminated due to nonpayment of Enrollee Premium Contributions reapplies and is determined eligible for Commonwealth Care after 24 or more months have passed since the termination of eligibility, the outstanding Enrollee Premium Contribution payments are waived.

(5) Waiver or Reduction of Enrollee Premium Contribution for Extreme Financial Hardship.

(a) Extreme financial hardship means that the Enrollee has shown to the satisfaction of the Connector that the Enrollee:

1. is homeless, or is more than 30 days in arrears in rent or mortgage payments, or has received a current eviction or foreclosure notice; or

2. has a current shut-off notice, or has been shut off, or has a current refusal to deliver essential utilities (gas, electric, oil, water, or sole telephone); or

3. within the 24 month period immediately preceding the date of the waiver application, incurred non-cosmetic medical and/or dental out-of-pocket expenses for the Enrollee and/or Enrollee's household members (exclusive of premium and co-payments), that are not subject to payment by a third party, and that totaled more than 7.5% of the Enrollee's gross family income during that time period. (In this case "non-cosmetic medical and/or dental out-of-pocket expenses" must be incurred by the individual or family for services rendered while enrolled in a Commonwealth Care plan or during a gap period of no more than nine months between periods of enrollment in Commonwealth Care and/or another state-subsidized health program, provided that the gap was not caused by an Enrollee's choice, by an Enrollee's re-determination of income, or by an Enrollee's non-compliance with Commonwealth Care rules or regulations; or

4. has incurred a significant, unexpected increase in essential expenses within the last six months resulting directly from the consequences of:

a. domestic violence;

b. the death of a spouse, family member, or partner with primary responsibility for child care;

c. the sudden need to provide full-time care for self, for an aging parent or for another family member, including a major, extended illness of a child that requires a working parent to hire a full-time caretaker for the child; or

d. a fire, flood, natural disaster, or other unexpected natural or human-caused event causing substantial household or personal damage for the Enrollee.

(b) If the Connector determines that the requirement to pay an Enrollee Premium Contribution or arrears results in extreme financial hardship for the Enrollee, the Connector may waive payment of such Contribution or arrears; or reduce the amount of such Contribution or arrears assessed to a particular individual.

(c) An Applicant who has been found eligible for Commonwealth Care may request a premium waiver prior to enrollment, although the filing of such request does not entitle such Applicant to enroll while the request is pending.

(d) If the Connector determines, in the case of an Enrollee who is in a Non-premium-paying Plan Type that the payment of any Co-payment results in extreme financial hardship for such Enrollee, the Connector may waive any Co-payment incurred by such Enrollee. Enrollees in a Non-premium paying Plan Type who are homeless and have reported that status to the MassHealth enrollment center will be granted a six-month Co-payment Waiver without the requirement of submitting a Co-payment Waiver Application and that waiver will be renewed at the Enrollee's request, as long as the homeless status is still reflected in the MassHealth Enrollment Center records.

(e) Hardship waivers will be authorized for up to 12 months. The waiver period begins in the month after a documented hardship waiver is granted. An Enrollee who is granted a hardship waiver will be assigned to the lowest cost Health Plan available in that Enrollee's Service Area. At the end of the waiver period, the Enrollee may submit another request. Requests for Enrollee Premium Contribution or Co-payment relief should be addressed to the Connector.

(f) Enrollees who have filed a premium waiver or reduction request will not be required to pay Enrollee Premium Contributions while the request is under consideration. Enrollees who have filed a copayment waiver request will not be required to pay Co-payments while the request is under consideration. If the Connector receives a request to waive or reduce Enrollee Premium Contributions from an Enrollee who has received a notice of termination for non-payment of Enrollee Premium Contributions, the filing of that request will stay the termination of the Enrollee while the request is under consideration, provided that the Connector receives the request more than five business days before the effective date of that termination. If the hardship waiver request is denied, the Enrollee will be required to resume paying Enrollee Premium Contributions or Co-payments, even if the Enrollee files an appeal pursuant to 956 CMR 3.14.

(g) Notwithstanding the provisions of 956 CMR 3.12(5)(f), if the waiver or reduction request is the second or subsequent such request made by the Enrollee, and the previous request was unsuccessful, the Connector will require the payment of Enrollee Premium Contributions and Co-payments, and, if applicable, proceed with a termination while the waiver or reduction request is under consideration.

(6) Voluntary Withdrawal. If an Enrollee wishes to voluntarily withdraw from receiving Commonwealth Care coverage, it is the Enrollee's responsibility to notify the Connector of his or her intention by phone or, preferably, in writing. Coverage continues through the end of the calendar month of withdrawal. The Enrollee is responsible for the payment of all Enrollee Premium Contributions up to and including the calendar month of withdrawal.

(7) Change in Enrollee Premium Contribution Calculation. The Enrollee Premium Contribution amount is recalculated when the Connector is informed of changes in income, family group size, or health-insurance status, and may be changed whenever the cost to the Connector of contracting with a Health Plan changes or as a result of a change in a Health Plan's Service Area.

(8) Minimum Monthly Commonwealth Care Enrollee Premium Contribution Schedule. The Board shall determine annually the minimum monthly Premium Contributions for each Plan Type. The Premium Contributions shall be set forth in a schedule that will be published annually.

(9) Monthly Commonwealth Care Premium Assistance Payments. The Premium Assistance Payments will be paid by the Connector monthly from funds appropriated by the Commonwealth for the purpose, or otherwise made available to the Connector, in amounts sufficient, together with the Enrollee Premium Contributions received by the Connector, to pay the Premiums due to the Contracted Health Plan.

(10) Termination of Health Insurance. If an Enrollee's Commonwealth Care coverage terminates for any reason, beginning the first day of the following month the Enrollee Premium Contributions and the allocable Premium Assistance Payments end.

Section 3.13 - Choosing a Contracted MMCO (Reserved)

Section 3.14 Right to a Hearing

Applicants and Enrollees are entitled to a fair hearing under 956 CMR 3.00 et seq. with either the Office of Medicaid Board of Hearings or a hearing with the Connector (depending on factors specified in 956 CMR 3.17 to appeal the following actions:

(1) any adverse eligibility decision based on income level or other MassHealth eligibility regulations at 130 CMR 501.000 et seq.;

(2) any adverse eligibility decision based on an Applicant's access to government-sponsored or employer-subsidized insurance;

(3) any determination that an Enrollee is not permitted to transfer from a current Health Plan because the Enrollee has not satisfied the requirements established by the Connector pursuant to 956 CMR 3.11(6);

(4) the Connector's disenrollment of an Enrollee for failure to pay Enrollee Premium Contributions or for any other reason other than loss of eligibility;

(5) the Connector's denial of a financial hardship waiver or renewal of a financial hardship waiver under 956 CMR 3.12(5); or

(6) for Enrollees in Plan Types II and III, any notice regarding their full payment of co-payments up to the specified maximum limit.

Section 3.15 Times and Methods for Filing Requests for Hearings

(1) The Applicant or Enrollee will receive a notice in writing of an Appealable Action identified in 956 CMR 3.14 from either MassHealth or the Connector. That notice will also include notice of the right to a hearing with the appropriate hearings office, of the method by which a hearing may be requested, and of the right to use an Appeal Representative. The notice will also include a form for appealing the action.

(2) The request for an appeal must be received within the following time limits:

a. 30 days after the receipt of the notice of the Appealable Action. (In the absence of evidence to the contrary, it will be presumed that the notice was received on the third day after mailing.);

b. 120 days from the date of a request for an eligibility determination, a transfer from a Health Plan or a financial hardship waiver or reduction when the MassHealth agency or the Connector fails to act on that request; or

c. 120 days from the date of an Appealable Action if the MassHealth agency or the Connector fails to send written notice of such action.

(3) The time periods in 956 CMR 3.15(2) will expire on the last day of such periods unless the day falls on a Saturday, Sunday, or legal holiday, in which event the last day of the time period will be deemed to be the following business day.

(4) Upon request by an Applicant or Enrollee, the Connector will provide the Applicant or Enrollee with a form to bring an appeal. The Connector and or its agent/designee may not restrict the Applicant's or Enrollee's freedom to request a hearing.

Section 3.16 Appeal from Health Plan Actions

Any inquiries, complaints or grievances by an Enrollee against a Health Plan, or any appeal by an Enrollee from an adverse determination by a Health Plan shall be subject to the review and appeal procedures contained in M.G.L. 176O, including appeals to the Office of Patient Protection within the Commonwealth's Department of Public Health, as set forth in 105 CMR 128.000.

Section 3.17 Hearings

(1) Fair hearings will be conducted for the Connector by the Board of Hearings within the Office of Medicaid using policies and procedures set forth in 130 CMR 610.00 and those set forth in 956 CMR 3.00, for those appeals brought under 956 CMR 3.13(1).

(2) Hearings for all other appeals will be conducted by the Connector using the policies and procedures for informal hearings set forth in 801 CMR 1.02, as well as the procedures set forth in 956 CMR 3.00 or in any administrative bulletins issued by the Connector;.

(3) The Connector may dismiss any request for hearing if
(a) it is not received within the time periods specified in 956 CMR 3.15;
(b) it does not state a valid ground for appeal under 956 CMR 3.14;
(c) the appeal is withdrawn by the Appellant or Appeal Representative; or

(d) for any reason stated in 801 CMR 1.02.

(4) The Connector may designate a hearing officer to hear any appeals. The hearing officer may, at the request of a party or on his or her own initiative, order that the hearing be conducted by telephone.

(5) The decision of the hearing officer designated by the Connector will be final, except that within 14 days of the issuance of the hearing officer's decision, the Director of the Appeals Unit for the Connector, or his designee, may, for good cause, and at the request of the appealing party or on his or her own initiative, order a re-hearing. In the event that the Director or the Director's designee orders a re-hearing, the Director will give notice in writing to all parties of the date, time, and location of the re-hearing. The re-hearing will be conducted before the Director or another hearing officer whom he designates. Within 30 days after the order requiring re-hearing, the Director or designated hearing officer will conduct the re-hearing and will either issue a superseding decision or decide not to issue a superseding decision. A request for re-hearing stays the initial decision of the hearing officer, and that initial decision will not be deemed final for purposes of the filing of an action for judicial review under G.L. c. 30A, § 14, until the Director or his designee issues a superseding decision or decides not to supersede the initial decision.

(6) Enrollees who have brought an appeal must continue to pay all required Enrollee Premium Contributions during the pendency of the appeal. Persons who are appealing a disenrollment because of non-payment of Enrollee Premium Contributions or for any other reason will remain disenrolled during the pendency of the appeal unless they obtain re-enrollment under the provisions of 956 CMR § 3.12(3). Persons who are appealing a denial of a premium waiver-reduction application or a copayment waiver application must pay Enrollee Premium Contributions and Co-payments while the appeal is pending.

Section 3.18 Administrative Information Bulletins

(1) The Connector may issue administrative information bulletins that set out policies that are consistent with the substantive provisions of 956 CMR 3.00. In addition, the Connector may issue administrative information bulletins, which specify the information and documentation necessary to implement 956 CMR 3.00. The Connector may also issue administrative bulletins containing interpretations of 956 CMR 3.00 and other information to assist persons subject to 956 CMR 3.00 meet their obligations under 956 CMR 3.00.

(2) Health Plans, Providers, and Eligible Individuals should refer to the Commonwealth Care Rules and Regulations, and other documents published affecting these plans and programs for more detailed information and guidance, including statements of policy and procedure, conditions of participation, guidelines, billing instructions, provider bulletins, Health Plan bulletins and other documents as necessary.

Section 3.19 Severability of Provisions

The provisions of 956 CMR 3.00 are hereby declared to be severable. If any such provisions or the application of such provisions or circumstances shall be held invalid or unconstitutional, such invalidity shall not be construed to affect the validity or constitutionality of any remaining provisions of 956 CMR 3.00 or the applications of such provisions or circumstances other than those held invalid.

REGULATORY AUTHORITY - 956 CMR 3.00: M.G.L. chs. 118H and 176Q.

Section 11
Young Adult Health Benefit Plans

Fact Sheet: Young Adult Health Benefit Plans

Final Regulations – Young Adult Health Benefit Plans

Young Adult Health Benefit Plans Fact Sheet

Status of Regulations: Final

Administrative Agency: The Connector

Effective Date: April 17, 2007

General Purpose

The general purpose of these regulations is to define coverage available to Massachusetts residents who do not have access to health insurance coverage through their employers and who are age 19 through age 26, i.e., the day before their 27th birthday.

Minimum Coverage Standards

Young adult health benefit plans are offered only through the Connector and must have been granted the Connector's Seal of Approval.

The plans must adhere to the following requirements:

- Annual out-of-pocket maximum for in-network covered medical services cannot exceed $5,000.
- The plan may include a limitation on covered medical services that is no less than $50,000 per illness, injury, or condition within a contract year or $50,000 per calendar year for in-network and out-of-network services combined.
- If included in a plan, the annual deductible for all covered medical services in total must not exceed $2,000 for in-network benefits.
- The plan may not include a procedural fee schedule for benefits.
- Such plans are to provide coverage of inpatient and outpatient hospital services, physician services for physical and mental illness, emergency services, and all other services mandated to be covered under MA law.
- Young adult plans may include reasonable co-payment coinsurance and deductible levels.

211 CMR: DIVISION OF INSURANCE

211 CMR 63.00: YOUNG ADULT HEALTH BENEFIT PLANS

Section

63.01: Purpose

The purpose of 211 CMR 63.00 is to define coverage for young adult health benefit plans.

63.02: Applicability

211 CMR 63.00 applies to all young adult health benefit plans offered, made effective, issued, delivered, or renewed through the Connector for delivery to any eligible young adult under M.G.L. c. 176J.

63.03: Authority

211 CMR 63.00 is issued under authority of M.G.L. c. 176J § 10.

63.04: Definitions

Carrier: an insurer licensed or otherwise authorized to transact accident and health insurance under M.G.L. c. 175; a nonprofit hospital service corporation organized under M.G.L. c. 176A; a non-profit medical service corporation organized under M.G.L. c. 176B; or a health maintenance organization organized under M.G.L. c. 176G.

Commissioner: the commissioner of insurance.

Connector: the Commonwealth Health Insurance Connector created under M.G.L. c. 176Q.

Creditable Coverage: Coverage of an individual under any of the following health plans with no lapse of coverage of more than 63 days for purposes of portability under 211 CMR 63.00 in relation to any pre-existing condition provision or waiting period:

(a) a group health plan;
(b) a health plan, including, but not limited to, a health plan issued, renewed or delivered within or without the commonwealth to an individual who is enrolled in a qualifying student health insurance program under M.G.L. c. 15A, § 18 or a qualifying student health program of another state;
(c) Part A or Part B of Title XVIII of the Social Security Act;
(d) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928;
(e) 10 U.S.C. 55;
(f) a medical care program of the Indian Health Service or of a tribal organization;
(g) a state health benefits risk pool;
(h) a health plan offered under 5 U.S.C. 89;
(i) a public health plan as defined in federal regulations authorized by the Public Health Service Act, section 2701(c)(I)(I), as amended by Public Law 104-191;
(j) a health benefit plan under the Peace Corps Act, 22 U.S.C. 2504(e);
(k) coverage for young adults as offered under section M.G.L. c. 176J, § 10; or
(l) any other qualifying coverage required by the Health Insurance Portability and Accountability Act of 1996, as it is amended, or by regulations promulgated under that act.

211 CMR 63.04: Creditable Coverage applies to creditable coverage for portability as used in 211 CMR 63.00 in relation to any pre-existing condition provision or waiting period. It is not intended to define minimum creditable coverage as defined by the Connector Board for purposes of determining individual responsibility for maintaining health coverage.

Date of Enrollment: with respect to an individual covered under a health benefit plan, the date of enrollment of the individual in the plan or coverage or, if earlier, the first day of the waiting period for such enrollment.

Eligible Young Adult: a Massachusetts resident from his/her nineteenth birthday up until the day before his/her 27th birthday who does not otherwise have access to health insurance coverage subsidized by the young adult's employer. For the purpose of identifying whether there is access to subsidized health coverage from the young adult's employer, a young adult will be considered to have access to such subsidized coverage, if the young adult's employer subsidizes at least 33% of the cost of the young adult's health insurance coverage.

Health Benefit Plan: any individual, general, blanket or group policy of health, accident and sickness insurance issued by an insurer licensed under M.G.L. c. 175; an individual or a group hospital service plan issued by a non-profit hospital corporation under M.G.L. c. 176A; an individual or a group medical service plan issued by a non-profit medical corporation under M.G.L. c. 176B; an individual or a group health maintenance contract issued by an HMO under M.G.L. c. 176G; a young adults health benefit plan under M.G.L. c. 176J, § 10.

Health benefit plans shall not include those plans whose benefits are for:

(a) accident only;
(b) credit only;
(c) limited scope vision or dental benefits if offered separately;

(d) hospital indemnity insurance policies if offered as independent, non-coordinated benefits which for the purposes of 211 CMR 63.00 shall mean policies issued under M.G.L. c. 175 which provide a benefit not to exceed $500 per day, as adjusted on an annual basis by the amount of increase in the average weekly wages in the commonwealth as defined in M.G.L. c. 152, § 1, to be paid to an insured or a dependent, including the spouse of an insured, on the basis of a hospitalization of the insured or a dependent;
(e) disability income insurance;
(f) coverage issued as a supplement to liability insurance;
(g) specified disease insurance that is purchased as a supplement and not as a substitute for a health plan and meets any requirements the commissioner by regulation may set;
(h) insurance arising out of a workers' compensation law or similar law;
(i) automobile medical payment insurance;
(j) insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in a liability insurance policy or equivalent self insurance;
(k) long-term care if offered separately;
(l) coverage supplemental to the coverage provided under 10 U.S.C. 55 if offered as a separate insurance policy;
(m) any policy subject to M.G.L. c. 176K or any similar policies issued on a group basis, Medicare Advantage plans or Medicare Prescription drug plans; or
(n) a health plan issued, renewed or delivered within or without the commonwealth to an individual who is enrolled in a qualifying student health insurance program under M.G.L. c. 15A, § 18 shall not be considered a health plan for the purposes of 211 CMR 63.00 and shall be governed by said M.G.L. c. 15A.

Minimum Creditable Coverage: Creditable Coverage determined to be sufficient to fulfill the individual health coverage mandate as defined by the Connector pursuant to M.G.L. c. 111M.

Pre-existing Conditions Provision: with respect to coverage, 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, regardless of whether any medical advice, diagnosis, care or treatment was recommended or received before the 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.

Procedural Fee Schedule: a fixed dollar amount to be paid for a specific service or episode of care.

Waiting Period: a period immediately subsequent to the effective date of an insured's coverage under a health benefit plan during which the plan does not pay for some or all hospital or medical expenses, but in all cases pays for emergency services.

63.05: Minimum Coverage Standards

(1) (a) All young adult health benefit plans are to be offered only through the Connector and must have been granted the Connector's seal of approval. Only carriers which, as of the close of any preceding calendar year, have a combined total of 5,000 or more eligible individuals, eligible employees and eligible dependents, who are enrolled in health benefit plans sold, issued, delivered, made effective or renewed to eligible small businesses or eligible individuals may offer young adult health benefit plans through the Connector. Enrollees in young adult health benefit plans shall not be counted toward the requirement that there be a total of 5,000 or more covered persons as of the end of a preceding calendar year.

(b) For the period July 1, 2007 through June 30, 2009 the following shall apply:

1. A carrier, together with any wholly-owned and/or wholly-controlled subsidiary of that carrier, that together had a combined total of 5,000 or more members (individuals, employees, and dependents) enrolled in health plans sold, issued, delivered, made effective or renewed to eligible small businesses or eligible individuals at the close of any preceding calendar year, may also offer young adult health benefit plans through the Connector.

2. In such a case, a carrier or wholly-owned subsidiary or wholly-controlled subsidiary that meets the 5,000 member requirement in combination with its wholly-owned or wholly-controlled subsidiary, but that by itself has less than 5,000 members, shall develop rates for young adult health benefit plans that are:
    a. consistent with the requirements of 211 CMR 63.07; and
    b. developed in combination with the rates that are developed for eligible small businesses and eligible individuals by the entity(s) with which it meets the requirement for a combined total of 5,000 members.

(2) Benefits:

(a) Young adult health benefit plans must adhere to the following requirements:

1. The young adult health benefit plans that include deductible(s) or coinsurance must include an annual out-of-pocket maximum for in-network covered services not to exceed $5,000 in total; provided, however, that this requirement shall not apply to a health benefit plan that includes coinsurance for only a limited number of non-core benefits that are not required to be part of a young adult health benefit plan, including, but not limited to, outpatient prescription drug coverage or durable medical equipment.

    a. The calculation of the out-of-pocket maximum must include the following payments made by the young adult for in-network covered services:
        i. copayments over $100,
        ii. coinsurance, and

iii. payments applied to deductibles.

b. Carriers may, but are not required to, exclude the following payments the young adult may make when calculating the out-of-pocket maximum:
   i. payments for non-covered services;
   ii. payments for services from out-of-network providers, such as payments applied to deductibles, copayments or coinsurance payments;
   iii. payments for services provided in emergency departments, such as payments applied to deductibles, copayments or coinsurance payments, unless the member is admitted to a hospital inpatient bed; and
   iv. in-network copayments under $100.
c. Carriers may, but are not required to, exclude amounts paid by the young adult for outpatient prescription drugs, whether as payments applied to deductibles, coinsurance or copayments, when calculating the out-of-pocket maximum.

2. Notwithstanding the annual out-of-pocket maximum for covered services, the young adult health benefit plan may include a limitation on covered medical services that is no less than either $50,000 per illness, injury, or condition within a contract year or $50,000 per calendar year for in-network and out-of network services combined.
3. If included in a young adult health benefit plan, the annual deductible for all covered medical services in total must not exceed $2,000 for in-network benefits.
4. The young adult health benefit plan may not include a procedural fee schedule of benefits.

(b) Such plans are to provide coverage of inpatient and outpatient hospital services, physician services for physical and mental illness, emergency services, and all other services mandated to be covered under Massachusetts law.
(c) Young adult health benefit plans may include reasonable copayment, coinsurance and deductible levels, subject to 211 CMR 63.05(2)(a), as approved by the Connector.
(d) Young adult health benefit plans may use cost control techniques commonly used in the health insurance industry, including tiered provider networks and selective provider contracting, as approved by the Connector.
(e) Any carrier offering young adult health benefit plans must offer at least one young adult health benefit plan that includes coverage for outpatient prescription drugs.

(3) A carrier is not required to issue a young adult health benefit plan to an eligible young adult if the carrier can demonstrate to the satisfaction of the commissioner that within the prior 12 months the eligible young adult has:
(a) made at least three or more late payments; or
(b) committed fraud, misrepresented the eligibility of a person as an eligible young adult or misrepresented information necessary to determine the health benefit plan premium rate; or
(c) failed to comply in a material manner with a health benefit plan provision; or

(d) voluntarily ceased coverage under that carrier's health benefit plan before the contract renewal date, provided that a carrier shall be required to credit the time such person was covered under prior creditable coverage provided by a carrier if the previous coverage was continuous to a date not more than 63 days prior to the date of the request for the new coverage.

(4) A carrier may request information from other carriers regarding the items listed in 211 CMR 63.05(3)(a) through (d) provided that the request does not violate any applicable state or federal law. The carrier receiving such a request from another carrier may provide the information consistent with state or federal law.

(5) A carrier is not required to issue a young adult health benefit plan to an eligible young adult if the young adult fails to comply with reasonable requests by the carrier for information relevant to the young adult's application for coverage, including but not limited to the information listed in 211 CMR 63.05(3)(a) through (d) and information regarding the young adult's access to health insurance coverage subsidized by the young adult's employer.

(6) A carrier is not required to issue a young adult health benefit plan to an eligible young adult if acceptance of an application would create for the carrier a condition of financial impairment. The carrier must file with the commissioner, at least 30 days in advance of any such denial or as soon as its financial position becomes known to the carrier, a certified statement by the Chief Financial Officer attesting to the carrier's overall financial impairment and accompanied by supporting documentation. Any carrier found to be financially impaired by the commissioner must immediately cease issuing policies on an initial basis to eligible young adults in accordance with the provisions of 211 CMR 63.05(9).

(7) A carrier is not required to issue a young adult health benefit plan, in the case of a carrier offering benefits through a network plan as part of an HMO (approved under M.G.L. c. 176G and 211 CMR 43.00) or insured preferred provider plan (approved under M.G.L. c. 176I and 211 CMR 51.00), if the young adult does not meet the carrier's requirements regarding residence within the carrier's network's approved service area;

(8) Any carrier who denies coverage under a young adult health benefit plan to an eligible young adult under the provisions of 211 CMR 63.05 must:
(a) provide to the young adult, in writing, the specific reason(s) for the denial of coverage; and
(b) make available to the commissioner and the Connector, upon request, the documentation for the denial.

(9) Discontinuance Provisions.
(a) Filing Requirements. Notwithstanding any other provision in 211 CMR 63.05, a carrier may deny a young adult enrollment in a young adult health benefit plan if the carrier certifies to the commissioner that the carrier intends to discontinue selling that young adult health benefit plan to new eligible young adults.

(b) Material to Be Submitted. A carrier that intends to discontinue selling a young adult health benefit plan to new eligible young adults must, at least 30 days in advance of discontinuing the sale of the health plan, submit to the commissioner and the Connector a statement certified by an officer of the carrier that specifies:
   1. The date by which it will discontinue selling the young adult health benefit plan to all new young adults;
   2. The reason(s) for the discontinuance of the young adult health benefit plan;
   3. A list of any other health benefit plans it intends to continue selling in Massachusetts;
   4. The number of young adults covered by the discontinued young adult health benefit plan, both in Massachusetts and in its total book of business; and
   5. An acknowledgment that the carrier is prohibited from selling the particular young adult health benefit plan again in Massachusetts to new young adults for a period of not less than three years.

(c) Notwithstanding any other provision in 211 CMR 63.05, carriers are required to renew coverage, as described in 211 CMR 63.06, under an otherwise discontinued young adult health benefit plan for young adults currently enrolled in such plan.

(d) The commissioner, in consultation with the executive director of the Connector, may disapprove, within 21 days of receiving notice under 211 CMR 63.05(9)(b), a carrier's election to discontinue the sale of a young adult health benefit plan if the carrier fails to comply with 211 CMR 63.05(9)(b) or is in violation of 211 CMR 63.05(10).

(10) In no event may a carrier deny a young adult enrollment in a young adult health benefit plan as part of an effort to circumvent the intent of M.G.L. c. 176J.

63.06: Renewability

(1) Every young adult health benefit plan must be renewable with respect to all eligible young adults at the option of the eligible young adult through the day before the young adult's 27th birthday except as provided in 211 CMR 63.06(2). A carrier shall continue coverage beyond the young adult's 27th birthday but only until the anniversary date of the young adult's enrollment in the young adult health plan.

(2) A carrier is not required to renew the young adult health benefit plan of an eligible young adult if the young adult by the renewal date:
   (a) has not paid the required premiums; or
   (b) has committed fraud, misrepresented whether a person is an eligible young adult, or misrepresented any information relevant to enrolling the young adult in the plan; or
   (c) failed to comply in a material manner with health benefit plan provisions including but not limited to the relocation of the young adult or dependent outside the service area of the carrier; or
   (d) fails to comply with reasonable requests to verify the information described in 211 CMR 63.05(3).

(3) A carrier must file with the commissioner any material changes in the criteria it uses under 211 CMR 63.06(2) to determine the nonrenewability of a young adult health benefit plan for

an eligible young adult as part of the annual filing it makes with the Connector as required by 211 CMR 63.09.

(4) A carrier must provide at least 60 days prior notice to an eligible young adult of the carrier's intention not to renew the health benefit plan and the specific reason(s) for the nonrenewal in accordance with the carrier's filed criteria.

(5) A carrier that elects to nonrenew all of its young adult health benefit plans delivered or issued for delivery to eligible young adults in Massachusetts:
   (a) must submit to the commissioner and Connector, 30 days in advance of providing notice required under 211 CMR 63.06(5)(c) a statement certified by an officer of the carrier that specifies:
      1. The date by which it will nonrenew all of its young adult health benefit plans to all young adults;
      2. The reason(s) for the nonrenewal of all young adult health benefit plans;
      3. The number of young adults covered by the nonrenewed health benefit plans, both in Massachusetts and in its total book of business; and
      4. An acknowledgment that the carrier is prohibited from writing new business in the young adult market in Massachusetts for a period of five years from the date of notice to the commissioner.
   (b) The commissioner, in consultation with the executive director of the Connector, may disapprove, within 21 days of receiving notice under 211 CMR 63.06(5)(a), a carrier's election to nonrenew if the carrier fails to comply with 211 CMR 63.06(5)(a) or is in violation of 211 CMR 63.06(6).
   (c) A carrier must provide notice of the decision not to renew coverage to all affected eligible young adults at least 180 days prior to the nonrenewal of any health benefit plan by the carrier in the event the commissioner has not disapproved the carrier's election to nonrenew; and
   (d) after the 180 day notification period, must nonrenew coverage to eligible young adults only on the date of renewal.

(6) Nothing in 211 CMR 63.06 prohibits a carrier from canceling during the term of the policy a health benefit plan issued to an eligible young adult for the reasons outlined in 211 CMR 63.06(2)(a), (b), or (c); provided that if the carrier cancels the health benefit plan for the reason found in 211 CMR 63.06(3)(a) during the policy term, a carrier must provide the eligible young adult with any grace period as provided in the health benefit plan, including any prior notification requirements.

(7) In no event may a carrier deny a young adult enrollment in or renewal of a young adult health benefit plan as part of an effort to circumvent the intent of M.G.L. c. 176J.

63.07: Rating of Young Adult Health Plans

Premiums charged to every eligible young adult for young adult health plans issued or renewed through the Connector must satisfy the rating requirements for small group health insurance

plans, as defined in 211 CMR 66.08 and carriers are required, when completing the actuarial filing required under 211 CMR 66.09, to certify that all rates offered to eligible small groups and eligible individuals, including those offered to eligible young adults through young adult health benefit plans, are in compliance with the relevant requirements of M.G.L. c. 176J.

63.08: Pre-existing Conditions and Waiting Periods

(1) No carrier may exclude any eligible young adult from a young adult health benefit plan on the basis of an actual or expected health condition, duration of coverage, or medical condition.

(2) No carrier may modify the coverage of an eligible young adult through riders or endorsements, or otherwise restrict or exclude coverage for certain diseases or medical conditions otherwise covered by the young adult health benefit plan except as otherwise permitted in this section 211 CMR 63.00.

(3) No policy may include pre-existing condition provisions that exclude coverage for a period beyond six months following the young adult's date of enrollment or waiting periods that exclude coverage for a period beyond four months following the young adult's date of enrollment. The pre-existing condition provision shall only relate to 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 such coverage and for which any medical advice, diagnosis, care or treatment was recommended or received during the six months before the young adult's date of enrollment. Pregnancy shall not be a pre-existing condition. Notwithstanding 211 CMR 63.08(3), no waiting period may be imposed if an eligible young adult lacked creditable coverage for 18 months or more immediately prior to the date of enrollment.

(4) When a young adult changes from one health benefit plan to another, whether such plan is with the same carrier or a different carrier, the carrier may impose a new waiting period of not more than four months on the young adult and for only those services covered under the new plan that were not covered under the old plan.

(5) In determining whether a pre-existing condition provision or waiting period applies to an eligible young adult, all young adult health benefit plans must credit the time the person was covered under prior creditable coverage if the prior creditable coverage was continuous to a date not more than 63 days prior to request for the new coverage, exclusive of any applicable services during the waiting period under the new coverage, provided that the prior creditable coverage was reasonably actuarially equivalent to the new coverage. For the purpose of 211 CMR 63.08(5), "reasonably actuarially equivalent" means the following:

(a) the Benefit Level Rate Adjustment factor for the new health benefit plan is no more than ten percentage points greater than the Benefit Level Rate Adjustment factor of the previous health benefit plan; provided, however, that if the Benefit Level Rate Adjustment factor for the new health benefit plan is more than ten percentage points greater than the Benefit Level Rate Adjustment factor of the previous health benefit plan, the eligible young adult must receive at least the benefits of the previous health benefit plan during the term of the pre-existing condition period or waiting period; or

(b) if the previous coverage is under Medicare or Medicaid, the previous coverage is presumed to be reasonably actuarially equivalent to the new health benefit plan.

(6) If a policy includes a waiting period, emergency services must be covered during the waiting period.

(7) A carrier may only impose either a pre-existing condition limitation or a waiting period.

63.09: Filing and Reporting Requirements

(1) Carriers must file all young adult health plans offered under 211 CMR 63.00 with the Division of Insurance and the Connector in accordance with 211 CMR 66.13.

(2) Carrier Reporting Requirements. On or before March 31st of each year, every carrier offering young adult health benefit plans under 211 CMR 63.00 must file electronically with the commissioner and the Connector two copies of a report verified by at least two principal officers of the carrier and covering its preceding calendar year; provided that, if the commissioner determines that a threat of financial impairment exists to the carrier, he or she may require submission of the report before March 31st. The report must contain at least the following information in a format specified by the commissioner:

(a) Number of young adult health benefit plans offered in Massachusetts during the preceding calendar year;

(b) Number of eligible young adults, as of the close of the preceding calendar year, who purchased a young adult health benefit plan from the carrier; and

(c) A copy of the criteria used to determine the nonrenewability of a young adult health benefit plan for an eligible young adult as described in 211 CMR 63.06(2).

63.10: Severability

If any section or portion of a section of 211 CMR 63.00, or the applicability thereof to any person or circumstance is held invalid by any court of competent jurisdiction, the remainder of 211 CMR 63.00, or the applicability thereof to other persons or circumstances, shall not be affected thereby.

Section 12
Frequently Asked Questions

General Health Care Reform Information

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General Health Care Reform Information

What does health care reform require of individuals and families?

Beginning December 31, 2007, Massachusetts residents 18 and older are required to have health insurance. This obligation is most commonly known as the "individual mandate." Effective January 1, 2009, compliance with the individual mandate depends not only on having coverage, but on whether or not that coverage meets the minimum standards established by the state. Compliance is determined through the filing of information on individual state income tax returns and the financial penalties for noncompliance are administered through the income tax system.

Individuals may request a waiver/exemption on the basis of:

- The affordability of available coverage
- Sincerely held religious beliefs
- Serious personal or family hardship

An approved waiver means that an individual may be uninsured, or under-insured, without penalty. It does not make available any government-paid or government-subsidized program for which the individual is not otherwise eligible.

What is required of employers?

The health care reform law created new insurance rules that apply to all group health plans written in Massachusetts, regardless of the size of the purchasing employer. These include expanded dependent eligibility and provisions related to nondiscrimination in the offer of coverage and percentage of premium contribution. (Section 8 of this Guide)

Employers of 11 or more full-time-equivalent (FTE) employees at a Massachusetts location must comply with the following primary obligations:

- Offer a Section 125 premium only plan that allows employees to pay for health insurance on a pre-tax basis and that complies with both federal and state rules. (Section 4 of this Guide)
- Make a "fair share contribution" toward the cost of health insurance coverage for their employees. (Section 6 of this Guide)
- Collect an Employee Health Insurance Responsibility Disclosure (HIRD) Form from all employees who waive participation in employer-sponsored health insurance or in a Section 125 plan. (Section 7 of this Guide)
- At the end of each tax year, provide Massachusetts Form 1099-HC to every employee who was covered under the employer-sponsored health insurance plan(s) at any time during that year. (Section 3 of this Guide)

Doesn't this really mean that employers must offer group health insurance?

No, there is no requirement that employers offer group health insurance. Covered employers are required, however, to make a "fair and reasonable" contribution toward the cost of health insurance coverage for their employees—called the fair share contribution obligation. Employers that do not offer group coverage, that make little or no contribution toward the premium cost, or that have very low take-up rates face the potential of a financial penalty – the fair share assessment – of up to $295 per full-time-equivalent employee per year. The funds collected from noncompliant employers are used to offset some of the cost of providing free or subsidized care within the state.

How does an employer determine if it is covered by the new law?

Employers with 11 or more full-time equivalent (FTE) employees working in a Massachusetts location must comply with the health care reform law. It is very important for employers to understand that the calculation of the number of FTE employees is based upon statutory and regulatory definitions and not upon how an individual employer defines "full-time" in its policies and practices.

For purposes of determining coverage under the law, one FTE employee is generally defined as 2,000 payroll hours in a year or 500 hours in a quarter. It is very possible, and very common, for an employer to have 11 or more FTE employees without having any employees who are actually classified as full-time under the employer's policies and practices. This is because the payroll hours of part-time employees must be included in the calculation, while including no more than 2,000 hours for any single individual.

All employees employed at a Massachusetts location for at least one month must be counted, regardless of where they live.

For full details on the calculation, including the definition of "payroll hours," please refer to Section 2 of this Reference Guide.

Is there a limit to the length of a waiting period an employer may require for group health insurance eligibility?

There is nothing in the health care reform law that dictates the length of the waiting period for group health insurance eligibility. Employers with waiting periods longer than 90 days should, however, be aware that this will create a problem if they must rely on passing the premium contribution standard test in order to comply with the fair share contribution obligation. That test requires the employer to contribute at least 33 percent toward the cost of individual coverage for all full-time employees employed at least 90 days.

Individuals who experience a break in coverage in excess of 63 days may face financial penalties for noncompliance with the individual mandate so the length of a waiting period may cause concern for some new or prospective employees.

How will employers prove that their employees have health insurance coverage?

There is no employer obligation to prove that employees have health insurance coverage. Each individual will verify his/her coverage through the state income tax return process. Also, the Employee Health Insurance Responsibility Disclosure (HIRD) Form, to be filled out by any employee who declines employer-sponsored coverage, collects information as to whether or not the employee has coverage elsewhere. Massachusetts employers are not expected to enforce the individual mandate under the health care reform law.

Some employers require employees, as a condition of employment, to enroll in the employer's group health plan unless they furnish proof of coverage elsewhere. This practice is voluntary on the part of the employer and is not required by any law or regulation.

Is Health Reform working?

Over 439,000 people were newly insured in Massachusetts since the health care reform law passed, according to an August 2008 report from the Massachusetts Division of Health Care Finance and Policy. Estimates vary on how many people were uninsured when the law was passed. But this is real progress, by any measure and places Massachusetts in the enviable position of having, at about 2.6 percent, the lowest rate of uninsured in the country.

For more information on how the law is working, see the Connector's 2007-2008 Progress Report in the Appendix of this Guide.

Individual Mandate

What is the individual mandate?

The individual mandate requires Massachusetts residents age 18 and older to have health insurance. As of January 1, 2009, the health insurance must have certain basic benefits.

NOTE: Individuals who are covered by Medicare Part A, MassHealth (Medicaid), TRICARE or registered for the health services of the U.S. Veterans Administration automatically comply with the individual mandate.

How is it determined if an individual is a "resident" of Massachusetts and, therefore, subject to the individual mandate?

Individuals are considered a resident if they "obtained any benefit, deduction, exemption, entitlement, license, permit or privilege by claiming that they are a resident of Massachusetts."

For example, individuals are generally considered to be a resident if they:

- Plan to file a Massachusetts resident tax form, or take advantage of certain exemptions or deductions allowed on the Massachusetts resident tax form. (Tax exemptions for residential property or rent are examples.)
- Declare on mortgage documents that a Massachusetts property is their principal residence.
- Declare on a homeowner's insurance policy that a Massachusetts property is their principal residence.
- File a certificate of residency with a Massachusetts city or town in order to take a job with a public agency or department.
- Pay in-state tuition rates at a community college, state college or university, including for a dependent.
- Apply for public assistance from the state, including for a dependent.
- Are the custodial parent or guardian of a child or dependent who is enrolled in a public school in a Massachusetts city or town (unless the individual or an outside jurisdiction is paying to send the child to that school).
- Register to vote in Massachusetts.

What benefits must individuals have in 2009?

As of January 1, 2009, individuals must have coverage that meets minimum creditable coverage standards in order to satisfy the individual mandate. Additional requirements become effective on January 1, 2010.

Health insurance companies licensed in Massachusetts must notify policyholders as to whether or not their plans meet minimum creditable coverage standards and must put a visible notice of compliance or noncompliance on their plan documents.

Are there exceptions to the Individual Mandate?

Individuals can request an exemption if they do not have health insurance because they believe it is not affordable for them, because of sincerely held religious beliefs, or because of serious personal or family hardship.

The individual mandate is enforced through the state income tax system and the exemption request process is initiated through the filing of the individual income tax return. The Massachusetts Department of Revenue refers exemption requests to the Connector for determination and denials may be appealed.

The financial penalty for noncompliance will be from zero to 50 percent of the premium cost of the least costly Bronze level plan offered through the Connector and factors such as income level will be considered. Penalties are assessed for each month of noncompliance and are collected through the income tax system.

How will individuals demonstrate that they are insured?

Individuals must provide information via their annual state income tax return on Schedule HC. Massachusetts carriers and employers must provide information, during January of each year, as to which individuals, including dependents on employer-sponsored plans, were covered at any time during each tax year.

This information is submitted on what is called a Form 1099-HC. Individuals will receive copies of the forms—a separate 1099-HC for each of the plans they were covered under during the tax year.

For employers who purchase group insurance in Massachusetts, the insurance carriers generally fulfill this obligation on behalf of their policyholders. Self-insured employers and those with insured plans written outside of Massachusetts must supply the information themselves, or arrange to have it supplied by their administrator or carrier.

Massachusetts residents who have coverage through a carrier or employer not covered by the health care reform law must obtain the required information through other means.

What information will be contained on the Form 1099-HC?

The forms contain information about the plan, as well as a list of all individuals who were covered during the year and their dates of coverage. Effective with the 2009 tax year, 1099-HCs must also indicate whether or not the coverage meets minimum creditable coverage standards.

How are the penalties collected?

Financial penalties may be assessed for each month of noncompliance and are collected by the Department of Revenue through the income tax system.

Minimum Creditable Coverage

What is Minimum Creditable Coverage?

Minimum creditable coverage (MCC) standards set forth the minimum levels of benefits Massachusetts residents age 18 and older must have in order to comply with the individual mandate. Between December 31, 2007and December 31, 2008, having virtually any type of coverage resulted in compliance. As of January 1, 2009, however, the MCC standards became effective.

Some key MCC requirements:

- Coverage of "core services" plus a "broad range of medical services" as set forth in the regulations. An expanded list of medical services applies beginning January 1, 2010.
- Prescription drug coverage with limits on deductibles
- Coverage for preventive visits prior to applying a deductible
- Annual deductibles of no more than $2,000 for an individual or $4,000 for a family
- Out-of-pocket limits no higher than $5,000 for an individual or $10,000 for a family
- No annual caps on core services or per-illness limits. Lifetime benefit caps are permitted as are annual caps on non-core services.

Coverage under multiple plans is aggregated to determine compliance, i.e., separate medical and prescription drug plans.

The final regulations include several safe harbor provisions designed to recognize compliance issues that arise around such things as non-traditional plan designs and employer-sponsored coverage governed by a collective bargaining agreement.

MCC is a complex issue – significant analysis, along with copies of very detailed regulatory guidance are included in Section 3 of this Guide.

Are group health plans offered by employers required to meet minimum creditable coverage standards?

No. It is not within the authority of the state to dictate the plan design of employer-sponsored health insurance, so employers are under no obligation to offer a plan that meets MCC requirements. The obligation is on individual residents to have coverage that complies with MCC. Otherwise, they fail to comply with the individual mandate.

This situation, however, creates an indirect, though very real, impact on employers since employees covered by a group plan that does not comply with MCC face the potential of financial penalty unless they arrange for additional coverage to fill the gaps. This might, at a minimum, create employee relations issues and, on a more strategic level, could impact an employer's ability to attract and retain staff.

How will MCC requirements be enforced?

The individual mandate is enforced by the Massachusetts Department of Revenue (DOR). Beginning with tax year 2009, the Schedule HC of the individual income tax return will require information related to MCC compliance and the Form 1099-HCs issued by Massachusetts carriers and employers will include an indication of whether the documented coverage complied with MCC.

How does an employer verify that its plan is compliant with MCC?

The one direct obligation placed on employers that offer group health insurance coverage is to determine whether or not their plans comply with MCC standards. In the great majority of cases, this is a relatively simple process of self-determination.

Most employers in the state purchase group health insurance through a Massachusetts carrier and all carriers are required by the Division of Insurance to prominently display symbols on contract documents indicating MCC compliance or non-compliance. The carrier, or broker, should be contacted if employers cannot locate their contract or do not readily find the compliance information.

Employers with self-funded plans or plans written in other states must review their plan(s) for MCC compliance. Those that are unable to make a determination, or that have plan designs offering a broad range of benefits but failing to comply with the details of MCC, must request certification from the Connector. Detailed information about the certification process, including the application form, is contained in Section 3 of this Guide.

If the Connector has difficulty making a determination from the information required through the certification application process, the employer may be required to submit an actuarial evaluation that will be used to determine if the benefits of the plan(s) are actuarially equivalent to, at a minimum, a Bronze level plan offered through the Connector.

Section 125 Premium Only Plan

What is a Section 125 Plan?

"Section 125" refers to a section of the Internal Revenue Service (IRS) Code which sets forth the rules under which employee benefits may be provided on a tax-favored basis. The Massachusetts health care reform law requires that employers of 11 or more full-time equivalent employees implement just one practice permitted under Section 125—a "premium only plan" that allows employees to pay for certain benefit plans, including health insurance, on a pre-tax basis.

Premium contribution amounts paid under a Section 125 plan are exempt from both state and federal income tax as well as Social Security and Medicare taxes. This results in significant savings – 30 percent on average – for employees. Employers also save since they do not pay the employer portion of Social Security and Medicare taxes. These savings typically exceed the cost of administering the plan.

Pre-tax premium payments are not new – does health reform change the way they work?

Premium only plans are not new and many employers implemented such a plan long before health care reform. The difference now is that covered employers are required to implement a plan which is now subject to state rules established by the Connector, as well as the longstanding federal rules. Noncompliant employers risk being subject to significant financial penalty if their employees, and/or dependents, utilize free care above statutorily specified levels.

The most significant administrative change introduced by the state rules is that the Section 125 pre-tax payment option must now be made available to certain employees who are not eligible for employer-sponsored coverage but who can now purchase insurance in the marketplace, within the requirements of the employer's Section 125 plan document, and pay for that coverage on a pre-tax basis through payroll deduction. Bringing this significant financial advantage to individuals who are not eligible for employer-sponsored health insurance was the driving force for this provision of the health care reform law.

How are pre-tax premium payments processed for non-group employees?

Employers have a number of plan design options for the processing of non-group premium payments. In all cases, an employee's pre-tax funds are set aside through payroll deduction. Those funds can, however, be disbursed in several ways, including:

- Directly to the carrier or insurance intermediary from whom an employee purchased insurance
- To the Connector, if the employer has established an account through which non-group employees purchase insurance and pay the premiums
- As a reimbursement to the employee upon receipt of documentation of premium payment

It is very possible for employees to owe more in premium than is available to them from their pre-tax deductions. This happens often when people work part-time variable schedules or when a full-time employee has an unpaid leave or other type of unpaid time off. When this happens, regardless of whether disbursements are made to a carrier, the Connector, or the employee, the employer should pay only the amount in the employee's pre-tax "account" at that time. It will then be up to the employee to pay the remainder of the premium using after-tax funds.

It is very important that employers make sure the plan document specifies how the plan will operate, and that the employer operates the plan as specified.

Can individuals purchase coverage through the Connector's Commonwealth Choice program and pay on a pre-tax basis through payroll deduction?

The Section 125 plan document must specify which insurance plans are eligible for pre-tax premium payment under the plan. If the Connector plans are included as coverage for which pre-tax payment is permitted, those premiums may be paid pre-tax through payroll deduction.

An employer should provide its employees with complete information about the availability of the Section 125 plan and its administrative rules.

Can individuals enrolled in Commonwealth Care, the state-subsidized insurance program, pay their contributions on a pre-tax basis?

As this Guide is published, Commonwealth Care participants who pay a portion of the cost of their coverage are not able to pay through pre-tax payroll deduction. They must make their payments directly to the program administrator using after-tax funds.

Does the Section 125 requirement apply to companies where the benefits are negotiated through a collective bargaining agreement?

Yes. The regulations state that, "Employees include, by way of example and not by way of limitation, full-time Employees, part-time Employees, Temporary Employees, and Seasonal Employees, regardless of whether his/her Employer is signatory to or obligated under a negotiated, bona fide collective bargaining agreement between such Employer and bona fide Employee representatives that governs the employment conditions of the Employee."

Does the Section 125 requirement apply to companies that pay 100% of the health insurance premium for their employees?

No. Employers of 11 or more full-time equivalent employees, that pay 100% of the cost of medical coverage for 100% of the employees who would be eligible for a Section 125 plan, if implemented, are not required to have a Section 125 plan because there would be no deductions to process.

The final regulations clarified that the 100% payment by the employer must apply to all tiers of coverage—for the employee *and* for all eligible dependents. The regulations are also clear in stating that this exclusion ends on the day an employer ceases to pay 100% of the coverage for all employees who would be eligible for a Section 125 plan if one were implemented.

This means, for example, that an employer that is currently exempt from the Section 125 requirement, as described above, hires one or more part-time employees who will not be eligible for the employer-sponsored plan, and who would be eligible for a Section 125 plan under state rules, the employer's exemption ends on the day the first part-time employee is hired.

If a person is "self-employed" according to IRS rules, is he/she eligible to participate in a Section 125 plan?

No—benefits under Section 125 are, according to federal rules, available only to people who are "employees." Individuals who are considered self-employed for income tax purposes are not employees. The people they employ, however, would be eligible. For example, the employees in a sole proprietorship or partnership situation could participate in a Section 125 plan, while the owner(s) could not.

Can the owner of a company participate in a Section 125 plan?

Yes, as long as the person is also considered an "employee," such as in a C-corp. situation. Incorporation is not the determining factor since, for example, someone who has at least 2% ownership of an S-Corp. is considered self-employed for IRS purposes.

What do I do when an employee declines health benefits or a Section 125 plan?

Employers with 11 or more full-time equivalent employees collect the Employee Health Insurance Responsibility Disclosure (HIRD) Form for each employee who declines to participate in either the employer-sponsored health plan or in the Section 125 Plan. Employers retain this form for 3 years. The Employee HIRD Form is available from the Mass. Division of Health Care Finance and Policy (DHCFP) in **English, Spanish** and **Portuguese**. See Section 7 for details and for copies of the forms.

How do I establish a Section 125 Plan?

Implementing a Section 125 plan requires, among other things, having a plan document that includes all required information and that is appropriately adopted by the employer. There are a number of related requirements as well. Since the plan document is binding on the employer, AIM strongly recommends consulting with a qualified benefits or legal expert for information, advice and document preparation.

It is not uncommon for consultants and payroll services to provide model documents to their clients and many of them are well done. Employers are cautioned against taking a plug and play approach to such documents since they may not reflect the way the employer wishes to administer its plan. It is recommended that plans developed by an employer from a model document be reviewed by a qualified benefits or legal expert.

As this Guide is published, the issuance of final federal Section 125 regulations is pending. The release of these long-overdue regulations along increasing focus in various states on mandated Section 125 benefits, it becomes even more important that employers understand federal and applicable state rules and that they administer their plans exactly as set forth in their plan documents.

The Connector's outstanding publication *Section 125 Plan Handbook for Employers* is included in the Appendix of this Guide. It contains very helpful information, checklists, and model documents.

Free Rider Surcharge

What is the Free Rider Surcharge and when will it apply?

One of the primary employer obligations under the health care reform law is to implement a Section 125 premium only plan that complies with both federal and state rules. Covered employers who fail to comply with this obligation potentially face a financial penalty called the free rider surcharge.

The surcharge is assessed by the state and will apply when, in greatly simplified terms, $50,000 or more in state-funded free care is utilized by the employees and/or dependents of the noncompliant employer during a 12-month determination period.

The surcharge amount will be determined according to a formula that takes into consideration the number of employees, the amount of free care used, the total cost to the state of that free care, and the percentage of employees enrolled in the employer's group health plan. But the employer will be liable for some portion of the actual medical expenses incurred so there is the potential of very significant financial liability.

Since the development and implementation of a Section 125 premium only plan is relatively inexpensive, and associated costs are typically more than offset by the savings on Social Security and Medicare taxes, covered employers are strongly encouraged to take the steps necessary to comply.

If an employer has a compliant Section 125 plan but employees and/or their dependents use significant amounts of free care during the waiting period for participation, will the employer be subject to the Free Rider Surcharge?

Having a compliant Section 125 plan in place allows the employer to avoid liability for the free rider surcharge. Such an employer will not be penalized for use of free care by employees and/or dependents during applicable waiting periods.

Fair Share Contribution

What is the Fair Share Contribution?

One of the primary provisions of the Massachusetts health care reform law requires covered employers to make a "fair and reasonable" contribution toward the cost of health insurance for their employees. Two compliance tests, developed by the Division of Health Care Finance and Policy (DHCFP), are used to define the "fair and reasonable" standard:

1. **Percentage of Full-Time Employees Enrolled Test**: Are at least 25% of full-time (as defined by the regulations) employees enrolled in the employer-sponsored group health insurance plan(s)?
2. **Premium Contribution Standard**: Does the employer offer to contribute at least 33% of the premium cost for individual coverage for all full-time (as defined by the regulations) employees no more than 90 days following the date of hire?

Compliance for the 12-month determination period of October of one year through September of the next year is determined through an online filing process developed and administered by the Division of Unemployment Assistance (DUA).

How are the two compliance tests applied?

Effective with the quarter of January 1 through March 31, 2009, the application of the tests changed significantly as follows:

- **Employers of 50 or fewer full-time equivalent employees** – Small employers will continue to comply with the fair share contribution obligation by passing just one of the two compliance tests.
- **Employers of more than 50 full-time equivalent employees** – Larger employers will automatically comply if at least 75% of full-time employees are enrolled in the employer-sponsored health insurance plan(s). If their take-up rate is less than 75%, they must pass both tests in order to comply.

How often must employers complete the online filing?

Effective October 1, 2008, fair share contribution compliance is determined through quarterly vs. annual filings as follows:

For Quarters Ending:	45-Day Filing Period
October 1 – December 31	January 1 – February 15
January 1 – March 31	April 1 – May 15
April 1 – June 30	July 1 – August 15
July 1 – September 30	October 1 – November 15

For the quarter ending December 31, 2008, all employers were required to file. How frequently individual employers must continue to file is determined in the sole discretion of the DUA. While employers that fail to comply or that are deemed to be "near-fails" or likely future-fails must continue to file at the end of each quarter, those that easily

comply may be notified that they are not required to file again until the end of the first quarter of the next determination period – October through December. Out of the approximately 34,000 employers required to file, it is expected that only about 1,200 will be required to continue filing on a quarterly basis—greatly reducing the administrative burden on both employers and the DUA.

All employers that receive a filing notice from the DUA are required to file. Covered employers must be aware of their obligations and must complete the filings whether or not they receive notice from the DUA.

What is the penalty if an employer is found to be out of compliance?

Employers that fail to comply with the fair share contribution standard will be assessed a financial penalty – often referred to as the "fair share assessment" – that is statutorily limited to $295 per full-time equivalent employee per year. The maximum of $295 has been applied as the penalty amount for all filings to date. A corresponding one-quarter of the annual penalty - $73.75 per full-time equivalent employee – is assessed as a result of the new quarterly filing requirements.

A 45-day filing period follows the end of each quarter. Employers must complete their filing and pay any penalty owed by the end of this period. Failure to file in a timely manner will result in an employer being assessed an additional 12% of any penalty owed. Penalties are collected through a direct debit to the employer's bank account.

What are my appeal rights in regard to the fair share contribution?

Once you certify your online fair share contribution filing and have been determined liable, you may submit an appeal in writing to the DUA's Fair Share Contribution Unit, 19 Staniford St, Boston, MA 02114. The appeal must be postmarked within 10 days of the certification date of your filing, or 30 days with good cause. The issues that can be addressed through an appeal are whether an employer is liable for the penalty and, if so, whether the amount of the contribution was correctly determined.

Note: A filing that is not certified cannot be appealed.

Can our fair share contribution filings be audited?

Yes, all fair share contribution compliance filings are subject to audit and/or validation by the DUA and/or other agencies of the Commonwealth.

What is a multi-employer plan? What if an employer contributes to a multi-employer plan?

Multi-employer health benefit plans, including those related to collective bargaining agreements, are plans to which more than one employer is required to contribute and which are maintained pursuant to one or more collective bargaining agreements. For purposes of fair share compliance compliance, the Division of Health Care Finance and Policy has ruled that an employer that makes a contribution to a multi-employer health benefit plan on behalf of a full-time employee may include that full-time employee in the number of employees enrolled in the health plan. Also, for purposes of completing the primary test, an employer under contract with the federal government that makes a contribution to a full-time employee's benefits in accordance with federal requirements may include that employee in the number of employees enrolled in the health plan.

How are part-time, temporary, and seasonal employees counted in the calculations?

It does not matter how an employer defines "full-time," "part-time," temporary" or "seasonal" in an employee handbook or through its employment practices. What matters is how the terms are defined under the law and in the various regulations. Generally, for purposes of complying with the health care reform law, the definitions are as follows:

- Full-time Employee: an employee who works 35 hours per week or the number of hours required to receive "full-time" benefits the majority of his/her time during the determination period, whichever is less
- Temporary Employee: a W-2 employee whose employment is explicitly temporary and who is employed for fewer than 12 consecutive weeks.
- Seasonal Employee: an employee who works for a "seasonal" employer, as determined by the Department of Unemployment Assistance, whose position has been certified by the DUA as seasonal, whose employment is limited to the beginning and end of the employer's season, and who is employed for no more than 16 weeks of the year.

Can employers skip the percentage of full-time employees enrolled test and go directly to the premium contribution standard test?

No. As part of the online compliance verification process, employers are required to complete the tests in order by entering data for the percentage of full-time employees enrolled test before being allowed to begin the premium contribution standard test.

What if an employer offers to contribute more than 33% for single coverage for one group of full-time equivalent employees but less for another group of full-time equivalent employees, or contributes more than 33% toward one plan and less for another?

Such an employer would not comply with the premium standard contribution test. The 33% must be offered for all plans offered to full-time employees.

My company has fewer than eleven (11) full-time equivalent employees. Do I need to file?

Any employer that receives a filing notice from the DUA must complete the filing. The agency retains complete discretion in determining which employers must complete the compliance filing. Both current and historical data will be used and this may result in some employers being required to file when they are not currently covered by the law. The first part of the online filing is the determination of coverage under the law. For employers whose calculation results in fewer than 11 full-time-equivalent employees this is the only part they will be required to complete.

Employers with 11 or more full-time equivalent employees are required to file whether or not they receive a filing notice from the DUA.

Our business is a temporary agency. Workers are sent to various locations. Do we have to include these workers in our fair share contribution filing?

If you are required to report these workers to DUA on your quarterly Unemployment Insurance Form 1 filing, then these workers are considered your employees and must be included in your fair share contribution filing.

We are a seasonal employer. Do we need to complete the fair share contribution compliance filing?

This is another example of the need to understand statutory and regulatory definitions as opposed to an employer's own terminology. In all areas of legal compliance, it is the statutory/regulatory definition that must be followed.

For purposes of health care reform compliance, no employer or employee may be considered "seasonal" until such a determination has been made by the Massachusetts Department of Workforce Development (MGL ch 151a § 24a). The rules for obtaining such certification are quite narrow and very few employers, and job titles at those employers, may legitimately be termed as being "seasonal."

We are a national company with employees who live in Massachusetts and work in another state, and employees who live outside of Massachusetts yet work in the state. Who do we report in the fair share contribution filing?

First, if you have multiple DUA numbers you will need to file separately under each DUA number that meets the filing criteria.

You should report only those employees that work in Massachusetts for an employing entity that is subject to Unemployment Insurance law M.G. L c.151A § 1. Employee residence is not a consideration for fair share contribution reporting.

My firm's group health insurance is self-insured. Do we need to file?

How your group health plan is funded has no bearing on whether or not you need to file for the fair share contribution report.

Our firm has multiple DUA numbers, but all locations are covered under the same group health insurance plans. Can I summarize the data and file under one of the numbers?

No. You must file separately for each DUA number for which you receive notification to file and/or for each DUA number that meets the filing criteria.

What happens when an employer fails to file timely?

DUA may first send a reminder notice to the employer to file. If non-filing persists, DUA will invoice the employer an estimated penalty amount.

Since many employers who are required to complete a fair share contribution filing may not owe the penalty, or may owe less than the amount estimated by DUA, it is in the employer's best interest to file in a timely manner.

If a penalty is owed, the law requires DUA to assess additional penalties on employers who fail to pay timely. By regulation the penalty is set at 12% per year on unpaid amounts. DUA has no authority to waive those additional charges.

Continued failure of the employer to file and/or pay the required contribution may result in legal enforcement actions by DUA, such as receipt of a court judgment against the employer. Typical legal collection methods include bank levies and property liens to employers who persist in non-payment, and/or fail to meet the requirements of a payment plan agreement with DUA.

Who is responsible for fair share contribution filing for employees from a leasing company?

By DUA regulation, the client company is the "employer," not a leasing company who supplies workers to the client and/or handles payroll, tax, and/or other administrative functions for the client company. This means that the fair share contribution filing must be completed under the client company's DUA number, and must reflect the payroll, health insurance, and employment data related specifically to the client company.

What if an employer does not have access to a personal computer to complete the filing?

If an employer does not have access to a personal computer, there are locations where free access to a PC can be obtained. These include the 32 One-stop Career Centers across the Commonwealth as well as most public libraries. Employers may also contact the fair share contribution office at (617)-626-6080 (option 3) to schedule use of a computer in the Employer Assistance Center located at 19 Staniford Street, Floor 5, Boston, MA 02114.

Health Insurance Responsibility Disclosure (HIRD) Obligation

What is the HIRD provision designed to accomplish?

The Health Insurance Responsibility and Disclosure (HIRD) provision of the Massachusetts health care reform law is designed to collect compliance information from both employers and individuals.

What is the filing date for the Employer HIRD Form?

There is no actual Employer HIRD "Form." Employer HIRD information, which is fairly extensive, is collected as part of the online fair share contribution compliance filing administered by the Division of Unemployment Assistance (DUA).

What type of information is collected from employers?

The information collected, as set forth in regulations from the Division of Health Care Finance and Policy, is as follows:

1) Employer legal name
2) Employer DBA name
3) Employer federal employer identification number
4) DUA number
5) Whether or not the employer has a compliant Section 125 plan
6) Whether or not the employer collects Employee HIRD Forms
7) Whether or not the employer contributes toward the cost of group health insurance for its employees
8) If so, the contribution percentage for each employee category
9) The total monthly premium cost for the lowest priced individual and family plan
10) The open enrollment period for the employer-sponsored plan(s)
11) Information about the employer's definition of "full-time," its eligibility rules for group health participation, and its participation in a multi-employer health plan.

What information is collected on the Employee HIRD Form?

The employee HIRD information collects information only from employees who waive participation in either the employer-sponsored health insurance or in a Section 125 premium only plan. Model forms are provided by the Division of Health Care Finance and Policy and are available in English, Spanish and Portuguese (included in Section 7 of this Guide). An employer may develop its own form as long as it collects all of the information included on the model form. Electronic forms and signatures are permissible.

The information collected:

1) Employee name
2) Employer name
3) Was the employee informed about the employer's Section 125 plan?
4) Did the employee decline to participate in the Section 125 plan?
5) Was the employee offered employer-subsidized health insurance?
6) Did the employee decline to enroll in the employer-subsidized coverage?
7) The employee portion of the least expensive individual coverage plan offered to the employee
8) Does the employee have health insurance coverage through another source?
9) The employee's signature, under penalties of perjury, and date of signature

An employee's signature on a HIRD Form signifies acknowledgment of his/her voluntary decision to waive participation as well as awareness of the individual mandate and potential penalty for noncompliance.

When does an employee have to fill out an Employee HIRD Form?

Any employee who waives participation in either a Section 125 plan or employer-sponsored health insurance has to fill out an Employee HIRD Form – each time they waive. This means employees who waive when they first become eligible and continue to waive during each open enrollment must complete a HIRD Form each time participation is offered and waived.

What are the recordkeeping requirements for Employee HIRD Forms?

Employees must be given a copy of their completed HIRD form since it may be needed in the process of their income tax filing or if they request an exemption from the individual mandate.

Employers must keep completed HIRD forms for 3 years.

Must the Employee HIRD forms be kept with medical files according to the requirements of the Americans With Disabilities Act?

While the Employee HIRD forms do not contain personal medical information that would require them to be filed with medical records, they certainly may be kept there if the employer wishes to do so.

For administrative ease, AIM recommends that employers consider the following:

1) Keep HIRD forms in a separate folder, expanding file, 3-ring binder, etc. – in alphabetical order for each tax year, and in a secure location. This makes is easy to locate forms if employees need copies, and it keeps them segregated from other records in case of an audit.

2) Purge the forms once a year, i.e., at the end of 2010 all forms signed in 2007 should be destroyed and so forth.

AIM generally recommends *not* keeping records any longer than required.

What if an employee fails to return the completed HIRD form to the employer?

Employers are expected to document their good faith efforts to collect the forms. If a form is never submitted by an employee, this documentation must be kept for 3 years in place of the form.

From a management/HR perspective, an employer may choose to initiate a corrective action/disciplinary process as a result of an employee's failure to comply with the reasonable operational request of the employer.

Impact on Insured vs. Self-Insured Group Health Plans

Which obligations under the health care reform law apply to employers with self-insured plans?

The obligations are exactly the same for covered employers with both insured and self-insured plans with the exception of provisions that are enforced by the state's Division of Insurance and which, therefore, apply only to group health insurance purchased from a Massachusetts carrier. These include the following rules:

- Expanded dependent eligibility requirement
- Nondiscrimination in offer of coverage and contribution toward premium cost

Details on these insured plan rules are included in Section 8 of this Guide.

Employers with self-insured plans may voluntarily choose to adopt these practices but are not required to do so since state insurance laws do not apply to self-insured plans.

How are the expanded dependent eligibility and nondiscrimination rules for Massachusetts insured plans enforced?

All group health insurance contracts written by Massachusetts carriers must contain dependent eligibility provisions consistent with the new rules and they are prohibited from selling a policy to an employer that does not comply with the nondiscrimination rule. The carriers, however, do not have responsibility for enforcement, i.e., making sure employers comply with the terms of the contract in the day-to-day operation of their plan(s).

An employer that purchases group health coverage in Massachusetts and is then found to be operating the plan(s) outside the contract terms is potentially placing the coverage at risk. Signing an insurance contract is just like signing any other contract – it binds the employer to the terms set forth in that legal document.

The Massachusetts Division of Insurance allows insured employers to discriminate in their premium contributions in favor of employees who participate in company-sponsored wellness programs. What constitutes a "wellness program"?

The bulletin issued by the Division of Insurance does not define a "wellness program." This means employers must review the nature and scope of their wellness programs and make a good faith determination of whether or not participation, or what level of participation, warrants differentiation in premium contributions. AIM encourages employers to fully document any wellness programs that are offered as well as which employees participate.

Do plans covered by collective bargaining agreements have to comply with the non-discrimination rules?

No, insurance plans written in Massachusetts and covered by collective bargaining agreements are not required to comply with the non-discrimination rules.

Commonwealth Choice

What is Commonwealth Choice?

Commonwealth Choice is the non-subsidized program administered by the Connector and through which individuals and small employers are able to purchase health insurance coverage. The plans offered through Commonwealth Choice carry the Connector's Seal of Approval and are from carriers throughout Massachusetts, including Blue Cross Blue Shield, Fallon Community Health Plan, Harvard Pilgrim Health Care, Health New England, Neighborhood Health Plan and Tufts Health Plan. Lower-cost Young Adult Health Benefit Plans are available for individuals ages 18 to 26.

Individuals eligible to purchase Commonwealth Choice through the Connector include:

- Unemployed individuals
- Employees who are not eligible for employer-sponsored coverage
- Employees who are eligible for employer-sponsored coverage but:
  - The employee needs to purchase coverage to be effective during their eligibility waiting period; or
  - The employer contributes less than 33% of the cost of individual coverage or 20% of the cost of family coverage; or
  - The coverage offered by the employer does not meet minimum creditable coverage standards
- Employees who work for an employer with fewer than 11 full-time equivalent employees regardless of their eligibility for employer-sponsored coverage or the employer's contribution level

Employers of up to 50 employees may arrange for coverage for their employees through a group concept developed by the Connector.

How are premiums paid when coverage is purchased through the Connector?

Generally, premiums are paid directly to the Connector by the individual or small employer purchasing the coverage. The Connector then remits funds to the various individual carriers.

The exception to this will be for employees of employers that establish an account with the Connector for the use of their non-group employees who wish to purchase coverage and pay the premium on a pre-tax basis through the employer's Section 125 premium-only plan. In these situations, the Connector invoices the employer and the invoices are then paid with the pre-tax money withheld from the employees.

The following questions apply to the interactions of the Connector and employers that choose to establish an account for non-group employees to purchase insurance and pay the premiums with pre-tax dollars through payroll deduction:

How will an employer know what amount to deduct for a Commonwealth Choice premium?

The Connector will notify the employer of the amount they should deduct from the employee's pay each pay period.

What happens if an employee does not have sufficient earnings to cover the Connector premium deduction?

The employer will remit whatever funds were deducted from the employee. The Connector will then be responsible for collecting any additional amount due, and the employee will be required to pay that amount in after-tax dollars.

How will an employer know if Connector premium deductions should be stopped or changed?

The Connector will provide very specific details as to when deductions should change or stop. Employees will need to interact directly with the Connector whenever they experience a change of status.

There will be situations where overpayments occur. In these cases, the Connector will send the overpayment back to the employer so the amount can be processed through the payroll system, taxes deducted, and the remainder paid to the employee. Pre-tax money cannot be refunded directly to the employee by the Connector.

What proof of employer coverage, if any, must a participant provide to the Connector in order to drop Connector coverage?

Individuals would not need any proof of employer-sponsored coverage to drop their Connector coverage.

It is important to point out that, if premiums are being paid through a Section 125 plan, mid-year changes are permitted only if the employer's plan allows them, and the nature of the changes is limited to very specific criteria contained in IRS regulations.

Will pre-tax deductions under a Section 125 plan be assigned a priority level by the state—for example, if the employee has other deductions or garnishments, what is the deduction hierarchy?

Employee benefit deductions are not treated like a wage garnishment. They are just normal payroll deductions, not unlike income and Social Security taxes and other employee-authorized deductions. You will need to understand how your payroll service, or internal payroll department, prioritizes deductions so you know what to expect for people with variable schedules and, therefore, variable pay.

What will the process be for refunding any premiums deducted from an employee's pay in error?

In the case of any overpayment, it will be necessary for the employer to refund the money through the payroll system since the refunded amount is now subject to state and federal income tax as well as Social Security and Medicare taxes. If the funds had already been remitted to the Connector, they will be returned to the employer for processing.

W-2 information may need to be adjusted if the refunds are processed after the closeout period for the applicable tax year.

Will eligibility for COBRA following loss of employer coverage make a person ineligible for a Connector plan?

No, since COBRA participants pay 100% of the cost of coverage, those individuals will have the option of accepting COBRA or purchasing a plan from the Connector or from a broker, intermediary, or directly from a carrier.

Commonwealth Care

What is Commonwealth Care?

The Commonwealth Care Health Insurance Program (Commonwealth Care) is a subsidized insurance program offered by the Connector to people with lower incomes and who meet other qualifications. It connects eligible Massachusetts residents with approved health plans and helps those residents pay for them.

Commonwealth Care plans are offered by Boston Medical Center (BMC) Health Net Plan, Fallon Community Health Plan, Neighborhood Health Plan and Network Health.

What are some guidelines for determining Commonwealth Care eligibility?

Generally individuals and families are eligible for Commonwealth Care if:

- Their income is no more than 300% of the federal poverty level
- They are uninsured
- They are a U.S. citizen/national, or legal alien and have resided in Massachusetts for at least the previous 6 months
- The policyholder is age 19 or older

Individuals are not eligible for Commonwealth Care if:

- They, or a family member, were offered group health insurance coverage by their current employer within the last six months AND that employer offered to pay at least 33% of the premium cost for individual coverage and/or 20% of the cost for family coverage
- They accepted cash in lieu of health insurance benefits from their employer, regardless of the employer's contribution level
- They are eligible for any of the following:
  - MassHealth (Medicaid)
  - Medicare
  - TRICARE
  - Insurance Partnership
  - Massachusetts Fisherman's Partnership Inc.
  - Qualifying Student Health Insurance Program
  - Massachusetts Division of Unemployment, Medical Security Plan
  - Coverage as a dependent under a family member's health insurance plan

Please clarify the rule about a person being offered health coverage through an employer within six months not being able to sign up for Commonwealth Care.

This provision was added to the law to prevent "crowd out" or the dropping of coverage by employers in favor of having their employees get subsidized insurance paid for by the state. It is a way to help keep the cost of Commonwealth Care affordable for the state**.**

The rule applies when the employer-sponsored coverage includes a contribution from the employer of at least 33% of the cost of single coverage and 20% of the cost of family coverage.

Individuals who accepted cash from their employers in lieu of benefits are also ineligible for the Commonwealth Care program.

How are premium amounts determined for Commonwealth Care coverage?

The cost of coverage for individuals and families with incomes up to 150% of the federal poverty level is paid completely by the state. Premiums are charged on a sliding scale basis for those with incomes from 151% to 300% of the federal poverty level.

Can Commonwealth Care premiums be paid on a pre-tax basis?

Pre-tax payment is not an option for Commonwealth Care at this time.

If an individual covered under Commonwealth Care becomes eligible for employer-sponsored health insurance, can they stay in the subsidized program?

If the employer contributes at least 33% toward the premium for individual coverage and/or 20% for family coverage, the individual is expected to enroll in the employer plan and would be disenrolled from Commonwealth Choice.

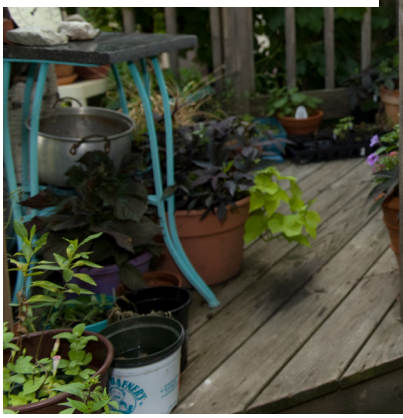
If the individual believes the employer plan is unaffordable, they may seek a waiver from the Connector which would allow them to be out of compliance with the individual mandate without penalty, but would not change their Commonwealth Care eligibility status.

Section 13
Appendix

Connector Massachusetts Health Care Reform 2007/2008 Progress Report

Section 125 Plan Handbook for Employers

Useful Websites

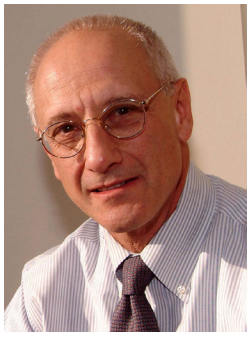


Commonwealth Connector

Massachusetts Health Care Reform

2007/2008 Progress Report

Message from the Chairman of the Board and Executive Director



After two years of comprehensive efforts throughout the Commonwealth, Massachusetts has added nearly 440,000 people to the rolls of the insured. In doing so, we have moved reform from an experiment to a success and have solidified its popular support. This summary report, which accompanies a lengthy, formal report on the Health Connector to the Massachusetts Legislature, reviews the progress achieved in implementing Health Care Reform in its first two years.

The most tangible measure of progress is the decline in the number of uninsured. Enrollment has occurred rapidly, ahead of expectations. Our Commonwealth Care program for low-income individuals has grown to 173,000 through August of 2008 and is making health insurance accessible to individuals who, up until now, went without. Some 43% of the newly insured are enrolled in private plans, not subsidized by the state, and a survey by the state Division of Health Care Finance and Policy for the first 21 months of the law's implementation shows that there is little evidence of a shift in enrollment from the private to the public sector. Furthermore, independent surveys of likely voters show steady progress in public support for the new law, as high as 71% in one study.

But most importantly, Health Care Reform is improving the lives of the citizens of Massachusetts. Newly insured individuals have access to the full range of care they need, including preventive care to keep them well. Indeed, a study by the Urban Institute shows that both low-income and higher-income adults report that they are less likely to have unmet health care needs since the law was implemented.

In this report, newly insured individuals tell their own stories, because those stories are fundamentally what Health Care Reform is all about. For example, Jaclyn Michalos, diagnosed with breast cancer shortly after joining Commonwealth Care, explains that having health insurance saved her life by enabling her to seek the care she needed without delay and worry about cost. Lynne Gassiraro, who is self-employed, now has the peace of mind of knowing that her new Commonwealth Choice plan provides financial protection against a number of serious health conditions she battles.

The Legislature, in its wisdom, asked the Health Connector's Board of Directors to make some groundbreaking and complex policy decisions to fully implement the new law. Comprised of individuals from diverse backgrounds and points of view, the Board has worked to make these decisions in a thoughtful and transparent manner, emphasizing cooperation and consensus.

Governor Deval Patrick and his Administration have worked tirelessly to ensure the success of the new law. The Massachusetts Legislature has shown unflagging commitment to Health Care Reform under the leadership of Senate President Therese Murray, House Speaker Salvatore DiMasi and Health Care Financing Chairs Richard Moore and Patricia Walrath. And finally, the Health Care Reform Coalition, made up of organizations, businesses and community groups who came together to support passage of reform, have held strong in their commitment to making it a reality in Massachusetts.

This Summary Report outlines progress to date for the newly created Health Connector and Massachusetts Health Care Reform. This summary is largely descriptive, as is the full report to the Legislature. Implementation of Health Care Reform is a three-year process, and many of the initiatives are still evolving. As these programs mature and we accumulate experience and data, we will turn increasingly toward evaluation and report our findings.

Leslie A. Kirwan

Leslie Kirwan, Chair
Secretary for Administration and Finance

Jon M. Kingsdale

Jon Kingsdale, Ph.D.
Executive Director, Commonwealth Health Insurance Connector Authority

Health Care Reform is literally saving the lives of people like Jaclyn Michalos of Norwood who is now cancer-free after undergoing treatment for breast cancer.

Contents

The Commonwealth Health Insurance Connector Authority is an independent state agency that helps Massachusetts residents find health insurance coverage and avoid tax penalties.

The Results are In

Two years after passage of Massachusetts' landmark Health Care Reform law, nearly 440,000 individuals are newly insured. Nearly half of the newly covered are enrolled in private plans with no government subsidies. To date, there is little evidence of crowd-out, or the shifting of enrollment from the private to the public sector. A report by the U.S. Census Bureau shows that gains made in enrollment in Massachusetts since the law was enacted have propelled the state from seventh place in the percentage of insured citizens to first place for the 2006 and 2007 period. The following report to the Massachusetts Legislature details the state's experience with Health Care Reform at its early stages.

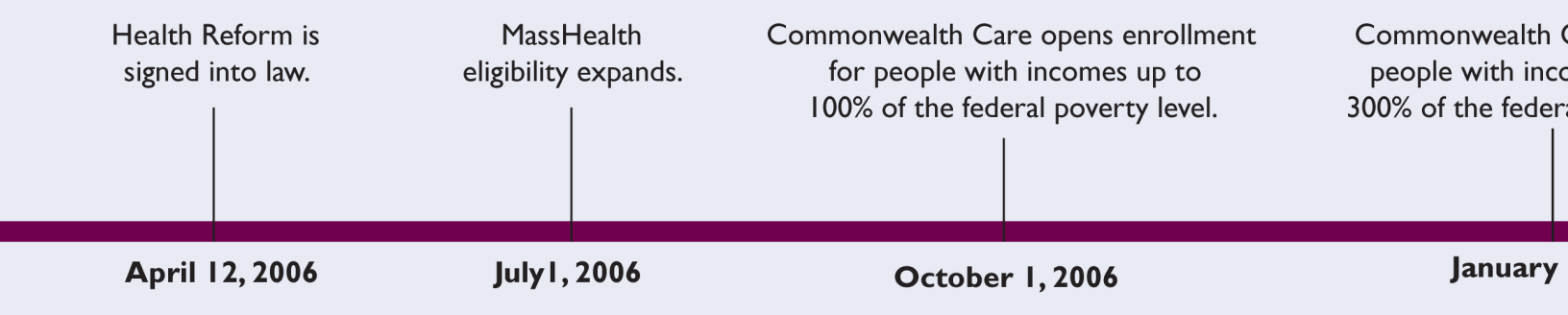
Implementation Begins

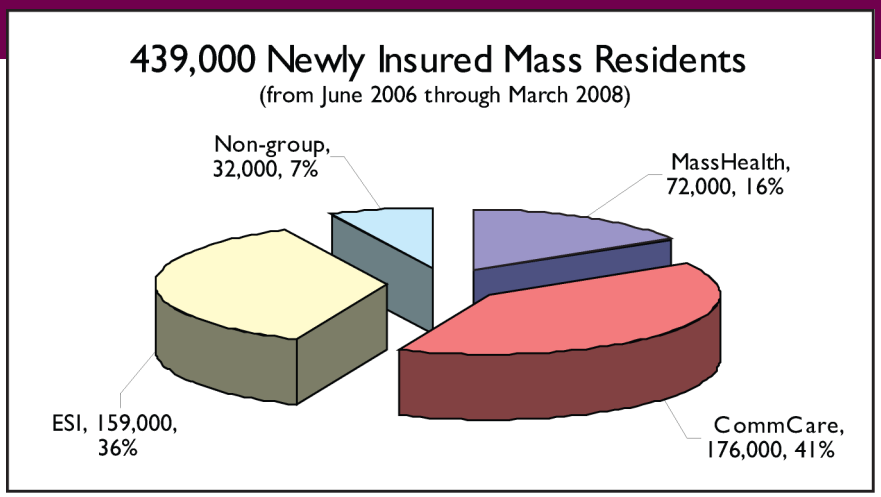
Chapter 58 of the Acts of 2006, was signed into law in April of 2006. Work on implementation began immediately with the expansion of MassHealth eligibility and the promulgation of the first set of emergency regulations from the Massachusetts Health Insurance Connector Authority.

The Health Connector first began to offer subsidized coverage for uninsured adults with the lowest incomes in October 2006 for a November 1 effective date, and three months later extended this offering to those from 100 to 300% of the federal poverty level (fpl). Commonwealth Choice, the Health Connector's program for individuals not eligible for subsidized coverage, opened in May 2007, for an effective date of July 2007.

The three-year phase-in of Health Care Reform in Massachusetts continues with an increase in tax penalties for 2008 and implementation of new standards for Minimum Creditable Coverage in 2009. Also planned for early 2009 is the extension of the Commonwealth Choice program to small employers

Two years after beginning implementation and phase-in of the law, Massachusetts has passed a number of significant milestones. Most importantly, more Bay Staters now have health insurance. Based on information collected by the Division of Health Care Finance and Policy (DHCFP), 57% of the almost 440,000 newly insured are enrolled in Commonwealth Care or MassHealth and 43% are in private insurance. Well over half of the new enrollees contribute all or something significant to the premium cost of their coverage and



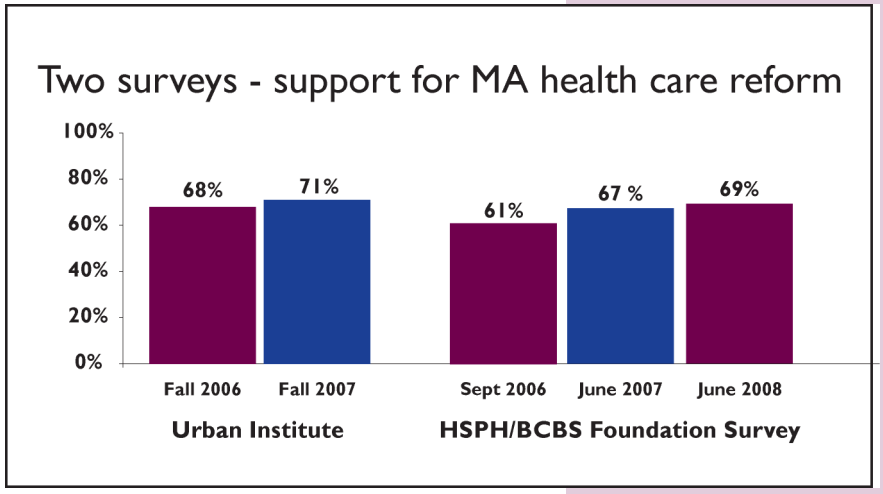


incur co-payments and other cost-sharing in line with private employer-sponsored insurance. (This DHCFP data is from the first 21 months of the law's implementation, from June of 2006 through March of 2008.)

Based on data from fall of 2007— both survey data and tax filings — the number of uninsured in Massachusetts has fallen substantially. A state survey of the uninsured due out at the end of 2008 will provide more definitive information on the remaining number of uninsured.

In addition to launching two major coverage programs in its first year — subsidized Commonwealth Care and unsubsidized Commonwealth Choice — the Health Connector's Board of Directors met 25 times to wrestle with a number of critical and high profile policy decisions. Most of these matters were decided unanimously. The Board's successful efforts to reach consensus are in keeping with the earnest efforts of many interested parties dedicated to implementation of the landmark legislation.

Soon after its enactment, popular support for Health Care Reform was already high. Remarkably, in the two years since, public support in Massachusetts has actually increased.



Care opens for
omes of up to
al poverty level.

Open enrollment begins for Commonwealth Choice.

With some exceptions, Massachusetts adults must have health insurance.

Changes to Health Safety Net regulations take effect.

1, 2007

May 1, 2007

July 1, 2007

October 1, 2007

Having health insurance is helping people like Madelyn Rhenisch reclaim their lives.

"Your job ends, accidents occur and health issues arise," said Madelyn. "And when you have health problems and no insurance, you struggle. I stopped getting routine and preventive care, saw doctors only when I couldn't find any self-help way of healing myself, and I lived in fear of an illness or accident that I wouldn't be able to afford."

When Madelyn did develop health issues, it didn't take long for her to lose all the retirement money she had worked so hard to set aside.

On Oct. 2, 2006, she became the first person in Massachusetts to enroll in Commonwealth Care, one of the Health Connector's landmark programs that provides quality care at a reasonable price. Today there are some 440,000 newly insured in either public or private market insurance.

"I no longer live in fear of the next illness or accident," said Madelyn. "Without the foundation of health, you cannot hold your own or contribute. You cannot use your skills and resources to build a strong life and community."

Madelyn no longer has to decide between medicine and food. She now gets the routine care she needs, and as her health is restored, she feels secure and is filled with hope.

"I am proud to live in the first state to take on the responsibility of ensuring health care for all its citizens," said Madelyn. "Whatever costs are incurred are more than repaid by the ability of people like myself to regain their health and step back into the role of contributing citizens."

And beyond our borders, this legislation is often examined as a possible model for national health reform.

Due in part to an aggressive public education program, enrollment growth in Commonwealth Care peaked just as the individual mandate penalties came into effect at the end of 2007. With the introduction of a comprehensive process for annually re-determining eligibility, enrollment in Commonwealth Care leveled off in March 2008 at approximately 176,000 while growth in MassHealth has reached about 72,000. The Health Connector projects that growth in the program will soon resume. The portion of premium-paying enrollees in Commonwealth Care continues to grow, as does enrollment in private, commercial insurance.

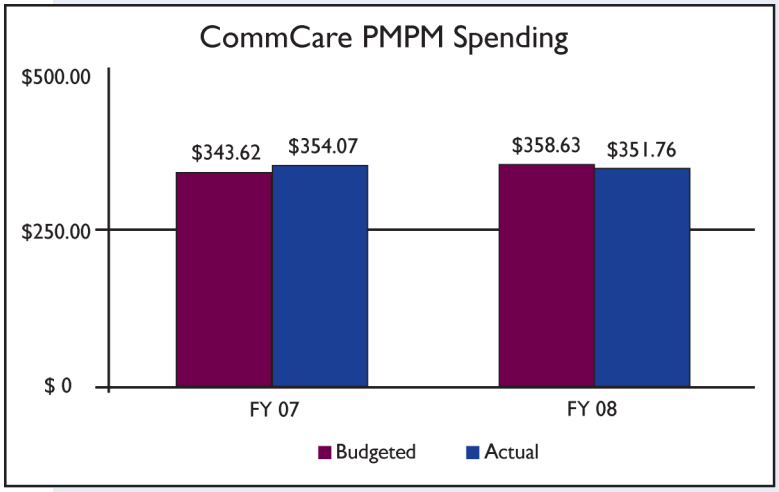
The rapid pace of the growth in Commonwealth Care has generated cost concerns. In fact, spending on Commonwealth Care exceeded early budget projections for FY 2008 by over $150 million. However, as a relatively new program expected to grow at rates which can only be estimated in its early years, enrollment growth is more an indicator of need than anything else. On the basis of cost per member per month, Commonwealth Care has tracked close to budget for the past two years.

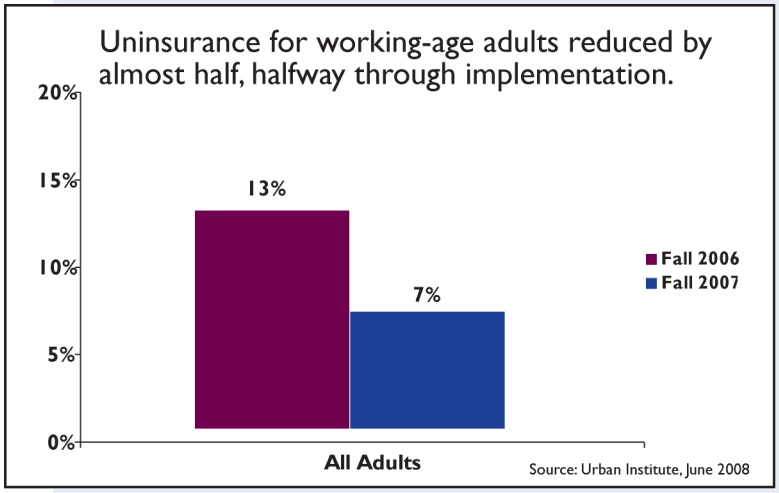
Meanwhile, a look at available data begins to paint a picture of initial success, not only in covering more individuals, but in improving access to routine care and reducing reliance on "free care." A survey by the Urban

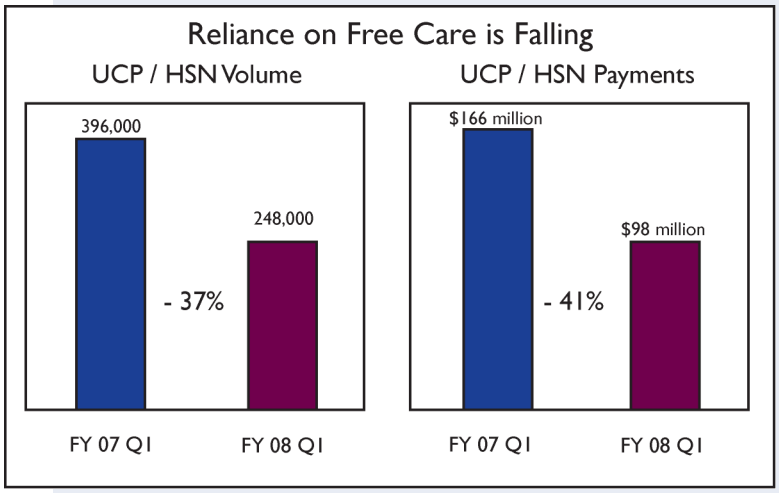
Institute reports that from the fall of 2006 to the fall of 2007, the number of uninsured adults in Massachusetts dropped almost in half, from 13% to 7%. Because seniors and children were not included in the survey and have far higher rates of insurance than working-age adults, the overall percentage of uninsured was likely lower. Moreover, the survey was conducted in October and November of 2007, before penalties for complying with the new law went into effect, prompting a large surge in enrollment.

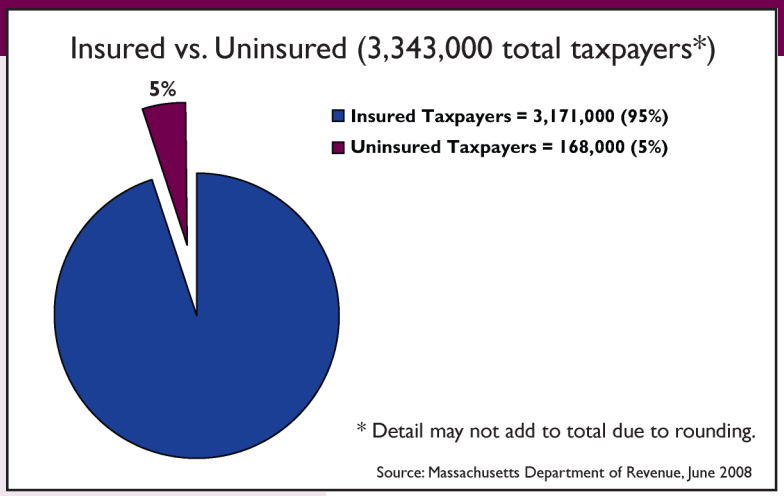
The Urban Institute findings are corroborated by the annual U.S. Census Bureau survey that showed the state's average uninsured rate for the two-year period, 2006-2007, dropped to 7.9%, making Massachusetts the state with the lowest rate of uninsured residents in the country. As predicted, the use and cost of the Health Safety Net for the uninsured is falling. As reported by DHCFP, utilization of free care had declined by 37% and payments declined by 41%, in the first quarter of Health Safety Net fiscal year 2008 over the same quarter a year earlier. As intended under the new law, increasing subsidies for insurance and constricting eligibility for the Health Safety Net are moving cost from institutional subsidies to individual and comprehensive coverage.

The state Department of Revenue (DOR) has been a strong partner in the implementation of Health Care Reform. Communications to tax filers and employers explaining their responsibilities under the law have been undertaken through DOR, which is also responsible

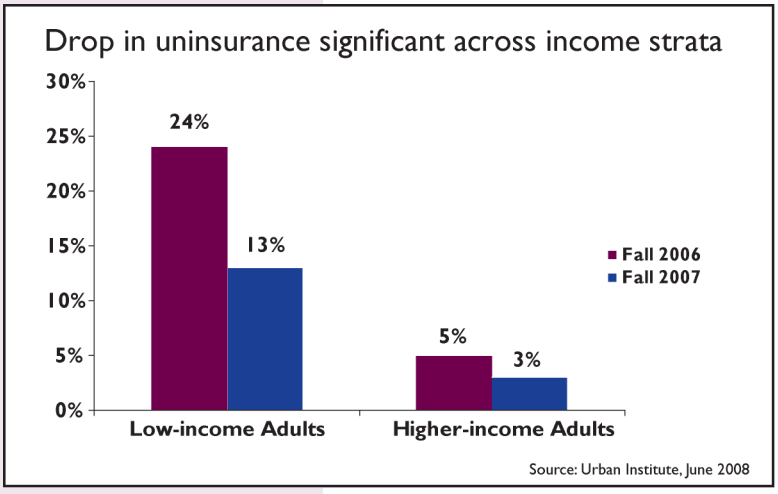








for implementing the schedule of tax penalties. DOR also serves as a source of important data about compliance. The department confirms a high level of coverage among adults through state income tax filings for 2007. Just 5% of some 3.3 million tax filers reported being uninsured as of Dec. 31, 2007, and compliance with the new tax filing requirements was overwhelmingly successful, with only 1.4% failing to file appropriately.



Of those Massachusetts taxpayers who reported not having health insurance, 3% (97,000) were deemed able to afford coverage, but self-assessed a penalty for not having it; the remaining 2% (71,000) were exempt from the requirement, either because they could not afford to purchase insurance, or because of their religious beliefs. As of August 2008, only 2,411 Massachusetts residents out of some 3.3 million filers had actually appealed the 2007 penalty decision.

Of the nearly 440,000 newly insured, as of March 2008, about 176,000 were enrolled in the Commonwealth Care program, 72,000 were receiving MassHealth, the state's Medicaid program, and 191,000 had enrolled in private insurance through their employers, the Commonwealth Choice program or because they purchased directly from a carrier.

The 43% who are enrolled in commercial health insurance plans represent the first significant increase in private, commercial insurance in Massachusetts in decades. Over half of the new enrollees contribute significantly toward their monthly premium, whether they pay all of it--as do some 32,000 new buyers of non-group insurance--or part, as do some 159,000 new enrollees who took up their employer's offer of insurance as well as more than 60,000 enrollees in government-

All employers with 11 or more full-time-equivalent employees in Massachusetts must offer a Section 125 Plan.

July 1, 2007

Employers with 11 or more full-time-equivalent Massachusetts employees must make a "fair and reasonable" contribution toward an employee health plan or pay an assessment.

October 1, 2007

Mass
th
health insu
income tax

subsidized Commonwealth Care. Among the 32,000 new buyers of non-group (individual) insurance, nearly 50% bought through the Health Connector, and 80% of that group utilized the Health Connector's award-winning web site for their purchases.

The Uninsured

The uninsured are disproportionately poor, so they make up a large portion of the newly insured, but Health Care Reform is helping people in need of coverage across the income spectrum. In the Urban Institute study, a significant decline in the numbers of uninsured was evident from 2006 to 2007 for both middle class adults and those earning 300% or less of the federal poverty level.

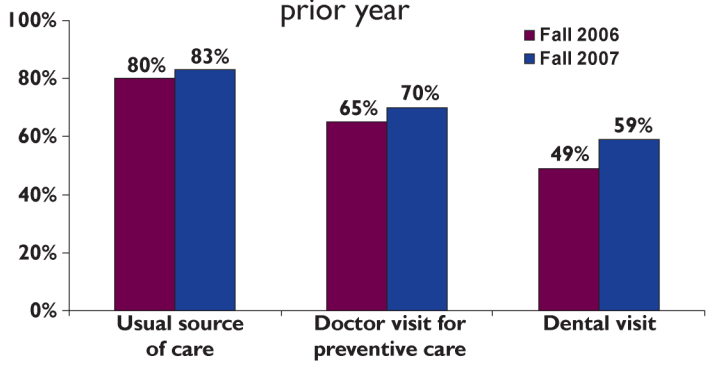
It is important to note that market reforms generated as a result of the new law significantly increased the choice and value of non-group health insurance in Massachusetts. Before reform, a healthy 37-year-old living in Boston – the median age for uninsured adults in the Bay State – paid $335 per month in premiums and had few market options. Post reform, that same 37-year-old had a broad range of options, including at least one plan for a little over half the price, with twice the benefits. In just nine months following reform of the non-group market, enrollment in individual plans doubled from 36,000 to 72,000.

Plan choices for typical unisured 37-year-old

	Pre-reform	Post-reform
Monthly Premium	$335	$184
RX coverage	None	$100 deductible
Deductible	$5,000	$2,000

Increased access to medical care is a key goal of health reform, and the Urban Institute study showed that adults across income categories in Massachusetts have not only experienced increases in access to medical care, but have also experienced reduced out-of-pocket spending and increased use of preventive care services. In other words, Massachusetts insured hundreds of thousands of people who are now able to address previously unmet medical needs in a more affordable way.

Low-income adults more likely to have a regular health care provider and to have had health care visits over prior year



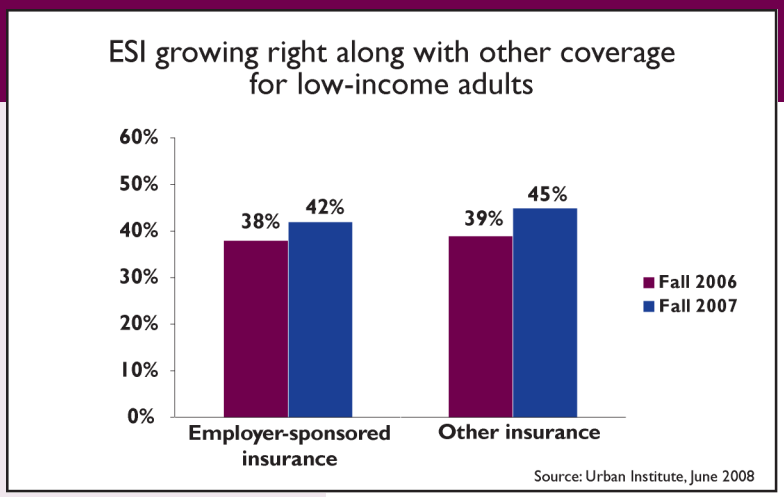
Source: Urban Institute, June 2008

sachusetts adults must show at they have enrolled in a urance plan or lose their personal deduction on their 2007 state taxes.

Penalties for adults who aren't insured increase.

Launch of Contributory Plan, New Minimum Creditable Coverage standards take effect.

December 31, 2007 | January 1, 2008 | January 1, 2009



Shared Responsibility
The reform law in Massachusetts has been an effort borne of shared responsibility among individuals, business and government. It's a formula that has proved attractive to voters. A survey by the Harvard School of Public Health and the Blue Cross Blue Shield of Massachusetts Foundation (HSPH/BCBSMA Foundation) showed that of the 93% of Massachusetts residents who say they know about the law, 69% support it. That support is up from 61% in September of 2006. Similarly, Urban Institute surveys in the fall of 2006 and fall of 2007 show a rise in favorable opinion among working-age adults from 68% to 71%, and those favorability ratings were similar for low-income and higher income respondents. When asked in the HSPH/BCBSMA Foundation study about repeal of the new law, only 12% of residents said they would like to see it repealed.

Support for the requirement that businesses with 11 or more employees provide health insurance or pay an assessment of up to $295 per employee per year is also growing, with the HSPH/BCBS Foundation survey showing support at 75% in June of 2008, up from 70% in September 2006. Additionally the study showed that 77% of Massachusetts residents supported providing subsidized health insurance to low-income residents.

The cost of the program has grown in response to enrollment growth. And, just as Commonwealth Care has grown, so has employer-sponsored insurance and private, non-group insurance. To date, there is no evidence of significant "crowd-out," or behavior changes from employers or employees that would shift enrollment from the private to the public sector.

None of this is to suggest that cost is not a concern. It is the major concern in any successful effort to significantly expand health coverage. By embracing the moral imperative to cover the uninsured, Massachusetts can no longer respond to medical cost increases by rationing financial access to care; instead, the challenge of moderating annual increases in the cost of medical care and health insurance must be squarely confronted. Legislation to do just that has recently been enacted and cost containment will continue to be a priority in the years ahead.

Connector Authority Administrative Cost
Prior to the commencement of operations, the Health Connector was provided an initial investment by the Legislature of $25 million. As the

Connector is a quasi-public agency, it is not a budgeted line-item for the Commonwealth of Massachusetts and, therefore, does not receive annual funds from the state to offset administrative costs. As such, the $25 million initial capitalization was expected to cover start-up expenses until the Connector generated sufficient revenue from members enrolled in Commonwealth Care and Commonwealth Choice to cover ongoing operating costs.

As expected, the Connector ran a significant operating loss in its first full fiscal year, while staffing up, launching programs and building initial enrollment. However, the Connector not only managed to reach break-even at the end of FY 2008, as budgeted, but is expecting to realize a modest net surplus for the year. FY 2008 results for the administrative budget are about $5 million better than expected. In the current fiscal year, the Health Connector projects a slightly better than break-even budget, even while reducing the administrative surcharge on Commonwealth Care from 4.5% last year to 4% this year. The Connector projects spending approximately $39.1 million in FY 2009 on revenues of $39.6 million. ■

Gabrielle Rene and Andre Bastien have worked hard for everything they have, yet they found themselves without health insurance for four months until they heard about the Health Connector.

"When I decided to become self-employed, I didn't know how I was going to be able to afford the rising cost of health insurance," said Andre. "Fortunately, my wife told me about the Health Connector."

And the plan they chose cost less than what they had been paying several months before.

"Getting started with the Health Connector is very easy," said Gabrielle. "All you have to do is check them out on the Internet and you'll see all the options. You and your family will have an opportunity to choose the plan that works best for you."

Very shortly after signing up for a Commonwealth Choice plan, Andre found himself in a hospital emergency room with chest pains. He didn't have to worry about spending thousands of dollars.

"With the Health Connector, I am able to have good health insurance, and that gives me peace of mind," said Andre.

Gabrielle and Andre are proud of what Massachusetts is doing to reduce the ranks of the uninsured.

"I am very happy to be in a state that is the leader of this new initiative. If you need health insurance, you really need to learn more about the Health Connector," said Andre.

Key Policy Decisions

Important policy and regulatory challenges that go beyond the administration of two new insurance programs were delegated to the Health Connector by the Legislature. The Connector established benefit packages and a progressive schedule of co-payments and premium schedules for Commonwealth Care enrollees who earn more than 100% of the federal poverty level. In setting these in 2007 and updating them in 2008, the Board succeeded in reaching a consensus that balanced the concerns about affordability while preventing the shift of cost from the private sector to government-subsidized plans and federal and state taxpayers.

Most Massachusetts residents are required to have health insurance. The Health Care Reform law assigned the Health Connector the challenge of setting "Minimum Creditable Coverage" (MCC), the standard of benefits needed to meet the individual mandate.

MCC sets a floor. The Health Connector and other state agencies deem any insurance benefits below the MCC level insufficient. In setting this floor, the Connector was guided by the need to balance premium and out-of-pocket costs, encourage preventive care and cover core medical services. These regulations require that as of Jan. 1, 2009, an MCC-compliant health insurance plan must cover a broad range of medical services, including:

- prescription drugs,
- visits to the doctor for preventive care, before any deductible,
- deductibles that are capped at $2,000 for an individual or $4,000 for a family each year,
- an annual cap on out-of-pocket spending at $5,000 for an individual or $10,000 for a family (for plans with up-front-deductibles or co-insurance), and
- no cap on total benefits for a particular sickness or for a single year.

As a result, Massachusetts is unique among the 50 states in requiring coverage of a broad array of medical services and prescription drugs, capping deductibles and out-of-pocket spending and requiring coverage of preventive care.

Those who cannot afford health insurance are exempt under the new

"It's unanimous."

The Board of the Health Connector includes members with diverse viewpoints from the business, government, labor, academic and health care sectors. Through vigorous debate and negotiation, these dedicated appointees have demonstrated a shared commitment to the success of Health Care Reform and always reached consensus on difficult questions of policy, including:

- Minimum Creditable Coverage, including the requirement for Rx benefits
- Affordability Schedules for the 2007 and 2008 tax years
- The appeals and exemptions process for the individual mandate
- Premium and co-pay schedules for Commonwealth Care members
- "Seal of Approval" decisions on Commonwealth Choice offerings
- Rules for employers who want to offer tax-free savings through a Commonwealth Choice "Section 125 Plan"

law from the individual mandate, and the Health Connector is charged with defining "affordability" and annually updating this schedule. Setting a fair schedule that also maintains the integrity of the individual mandate is one of the major policy challenges of reform. The Board of the Connector succeeded in reaching consensus twice on this controversial issue—originally in 2007 and again in 2008.

Tax Penalties

The individual mandate is enforced by tax penalties. If, according to the Affordability Schedule, a Massachusetts adult has an affordable, MCC-compliant health insurance option, he or she needs to enroll. If not, the individual could face tax penalties, unless he or she sought and received a hardship or religious exemption.

Although the individual mandate took effect on July 1, 2007, enforcement was tied to the last day of the tax year, Dec. 31, 2007. Adult tax filers who were not insured or exempt from the mandate on that date lost their $219 personal exemption when they filed their 2007 state tax return. Based on 2007 tax-filings to date, the 2007 Affordability Schedule exempted just over 60,000 people from the mandate and staff's analysis of the revised 2008 schedule suggests similar results for the current tax year.

In 2008, the penalty increases substantially and is based on income and broad age groupings. It will be assessed for each month an individual does not have health insurance and will be reported on the 2008 tax return. In 2008, the highest penalty for not having health insurance for the entire year is $912 for an individual.

Public compliance with the new filing requirements and potential resistance to the imposition of tax penalties for not having insurance were major areas of concern. It was critically important to the success of the Health Care Reform law that such issues be handled efficiently and fairly. The Health Connector and the state Department of Revenue have worked collaboratively to handle waiver requests and appeals related to the individual mandate in a fair and constructive manner. Of the 3.4 million Massachusetts residents who filed personal income tax returns with the state, only 1.4% failed to file their forms correctly and only 2,411 have appealed the tax penalty. ■

By the numbers:

- 95% of Massachusetts residents have health insurance.
- 58% of those who did not have health insurance were deemed able to afford insurance (97,000 tax filers).
- 37% (about 62,000 tax filers) were deemed unable to afford health insurance.
- 5.5% (or 9,000 tax filers) claimed a religious exemption from the mandate.

Approximate data from 2007 tax filings (with 86% of filings processed).

Supporters gather at the Massachusetts Statehouse to celebrate another milestone in the implementation of Health Care Reform. Speaking is Connector Board Chairwoman Leslie Kirwan.

Public Education & Outreach Campaign

Governor Deval Patrick addresses Health Care Reform supporters at the launch of the Public Education Campaign at Fenway Park in May of 2007.

The landmark Health Care Reform law, with its mandate that nearly all Massachusetts residents have health insurance and its employer requirements, necessitated an aggressive public education and outreach campaign. More than six million residents and some 193,000 employers needed to be informed of the benefits associated with having health insurance, tax penalties for not having it, and requirements affecting the business community. In November of 2006, as questions, concerns and confusion about the law began to mount, the Connector was tasked by the Secretaries of Health and Human Services and Administration and Finance to lead and coordinate communications about the many facets of reform to employers, insurers, brokers, Taft-Hartley fund administrators and the public in general,

To accomplish this, the Health Connector launched a multi-faceted outreach campaign that began

with its own Public Information Unit answering inquiries by phone and e-mail, and featured civic and corporate partnerships, grassroots enrollment events, direct mail, media outreach, educational forums and paid advertising across the state. While raising awareness of the new law and explaining its many facets, the campaign also promoted the availability of the Commonwealth Care and Commonwealth Choice programs.

Partnering with the Boston Red Sox, the Connector launched its Connect to Health campaign at Fenway Park in May of 2007. The Red Sox provided the Health Connector with support in numerous ways. For instance, an information booth was set up on the Fenway Park concourse and interviews were televised during games with Health Care Reform advocates like U.S. Senator Edward M. Kennedy and Governor Deval Patrick. The Red Sox helped with additional in-stadium messaging, bonus advertising, space in the Red Sox program, Connect to Health Days at Fenway and recently a public service announcement from Red Sox pitcher Tim Wakefield.

The Health Care Reform Coalition, which encompassed a host of independent organizations, including business groups, hospitals and providers, advocates and health plans, raised funding to launch an advertising campaign complementary to the Health Connector's and worked in tandem

Shopping for health insurance used to be a painstaking experience if you were self-employed. Just ask Lynne Gassiraro of Natick.

"You spend hours doing research and meeting with salespeople and in the end, you really don't know what you're getting yourself into," Lynne said. "I changed plans three or four times after reluctantly choosing one of those out-of-state, unknown companies, not realizing how inadequate it really was."

Lynne found herself in an emergency room in 2007 with a life threatening situation, a lengthy hospital stay and impending surgery. She was only 39 years old.

"I knew my insurance wouldn't cover everything, but I wasn't prepared for all the bills after I got home." Despite having insurance, she owed thousands of dollars.

That's when Lynne found out about the Health Connector.

"I was surprised how easy it was to compare plans, see clearly what was covered and get upfront pricing. The side-by-side comparison of products from local insurance companies was clear and easy to obtain."

Lynne's Commonwealth Choice plan came just at the right time. She recently had surgery for thyroid cancer and other ailments require her to see a cardiologist, gastroenterologist, pulmonologist and two endocrinologists.

"I am happy to have coverage that allows me to see specialists and have the tests and treatments I need," said Lynne.

"The Health Connector has been such a valuable resource for me. It literally saved my life. I tell my friends to check out the Health Connector and really compare coverage because I don't want them to experience the same problems I had."

Governor Deval Patrick thanks Red Sox CEO Larry Lucchino for the team's Health Care Reform partnership.

with the Connector on an array of outreach efforts. The Coalition included Partners HealthCare, Blue Cross and Blue Shield of Massachusetts and its Foundation, the Associated Industries of Massachusetts, the Massachusetts Business Roundtable, the Massachusetts Taxpayers Foundation, the Greater Boston Chamber of Commerce, Health Care for All, the Massachusetts Hospital Association, the Massachusetts League of Community Health Centers, Harvard Pilgrim Health Care, Tufts Health Plan, Neighborhood Health Plan, Children's Hospital, Boston, Massachusetts Eye and Ear Infirmary and Tufts Medical Center.

A unique feature of the success of Health Care Reform has been the sustained support of the various private sector organizations who helped enact the law and who continued to support and promote it during critical phases of implementation.

In order to raise awareness and understanding of the new law, a community-wide outreach effort was required and civic and private partnerships were critical. These partnerships were many and varied. For instance, the Greater Boston Interfaith Organization held enrollment sessions after religious services and went door-to-door with information and assistance. CVS Pharmacies provided in-store signage, informational materials and overhead radio announcements. Comcast provided pro bono advertising. The Associated Industries of Massachusetts, the Retailers Association of Massachusetts, and the Massachusetts branch of the National Federation of Independent Businesses all sponsored regional educational forums for employers in conjunction with the Health Connector.

The complete list of partnerships is extensive and includes: Bank of America, Market Basket Supermarkets, Shaw's and Star Supermarkets, the Massachusetts Department of Revenue, the Massachusetts Registry of Motor Vehicles, the Massachusetts Board of Higher Education, the Massachusetts Bay Transportation Authority, the Massachusetts Association of Realtors, the ACT Coalition , the Massachusetts Department of Public Health, the International Brotherhood of Electrical Workers, SEIU 1199, Price Chopper, Zipcar, the Massachusetts Association of Health Plans and carriers offering health insurance plans through the Health Connector.

The state also provided grant funding to community organizations for outreach and enrollment assistance on the regional as well as city and town level.

Market Research

Understanding the uninsured and the reasons that they lacked or resisted coverage was an important element of the outreach campaign.

The Health Connector undertook market research to understand its audiences and create appropriate messaging to effectively reach them. That research showed that two basic messages resonated with the uninsured, who are disproportionately young, male adults. Protection from financial ruin in the event of an unexpected accident or diagnosis hit a chord in focus groups with males while access to preventive care appealed to women.

The Health Connector launched a multifaceted ad campaign to build awareness of the law and drive enrollment.

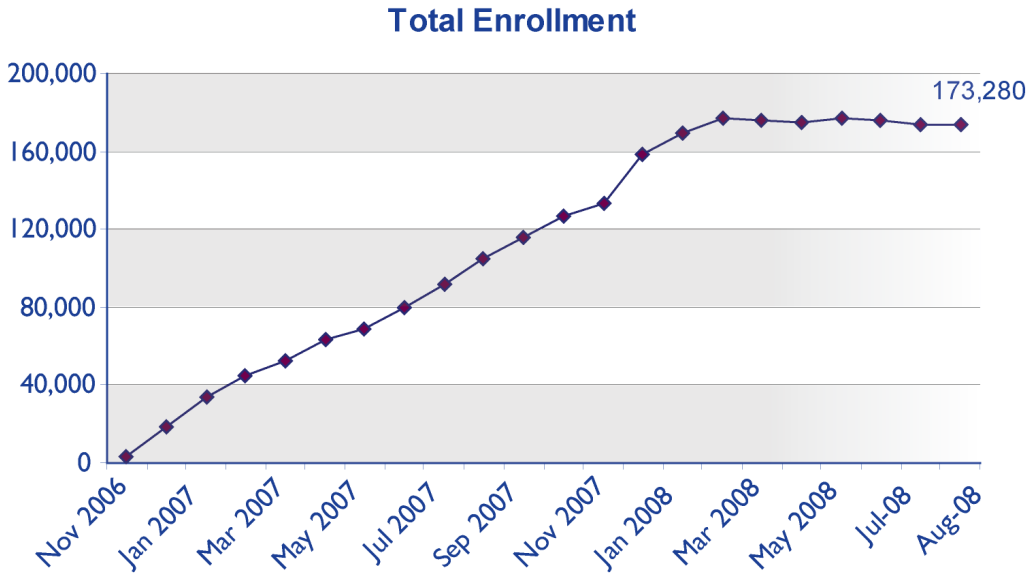
Advertising was influenced by market research and included television, radio, print and Internet applications. Ethnic media was also a special focus. Direct mail was utilized with two postcards sent to the homes of all tax filers reminding them of the deadline for enrolling in health insurance before tax penalties would be incurred. Similar communications were sent to all employers. Additionally, the Department of Revenue sent a follow-up letter to all tax filers who were assessed the penalty for not having health insurance in 2007. This mailing explained increasing fines for 2008 and provided advice about where to obtain health insurance. Promotional and informational materials were also produced for widespread distribution.

The Connector and its partners held 30 grassroots enrollment events across the state in conjunction with state legislators, city and town officials, local hospitals, community health centers and community groups. While helping the uninsured enroll in heath insurance, the events also generated regional and national news coverage.

These community-wide efforts drove enrollment in health insurance and knowledge of the law. Independent surveys placed knowledge of the requirement that all residents have health insurance at 87% in late 2007. A more recent survey in June of 2008 by the Harvard School of Public Health and the Blue Cross Blue Shield of Massachusetts Foundation reports that 93% of Massachusetts residents say they know at least something about the new law. ■

Commonwealth Care

Putting Coverage within



Commonwealth Care is the Health Connector's subsidized health insurance program that connects eligible Massachusetts adult residents with approved health plans. Launched in October of 2006, Commonwealth Care insured more than 173,000 Massachusetts adults, as of Aug. 1, 2008. (Of that total, more than 60,000 are paying a monthly premium.) Children of enrollees are covered by MassHealth without a premium.

Uninsured households with incomes up to 300% of the federal poverty level, currently $31,212 for an individual and $63,612 for a family of four, may qualify for a subsidy. For those with family incomes up to 150% of the fpl, there are no monthly premiums. Members of Commonwealth Care choose a health plan and their own doctor. Benefits include regular check-ups, treatments for sickness or injury, prescriptions, vision care, mental health, substance abuse treatment and, for some members, dental care.

The program offers a health insurance option to those individuals who may not have qualified for a Medicaid program and those who may never have considered a government subsidized health insurance program.

For households with incomes above 100% of fpl, the Commonwealth Care model closely resembles that of commercial insurance plans with monthly premium payments for some members and co-payments for services and prescriptions. As of July 1, 2008, premium contributions for the lowest cost plans range from $39 to $116 depending upon an individual's income.

Enrollment in Commonwealth Care has grown faster than expected due to an aggressive outreach and public education campaign and the

Reach

fact that there were more uninsured individuals in Massachusetts than initially projected.

As the program continues to develop, the focus has shifted from enrolling the uninsured to maintaining and strengthening the program for the long-term.

Great strides have been made to connect individuals with health insurance. This would not have been possible without strong relationships between state agencies such as the state's Office of Medicaid (MassHealth) and the Division of Health Care Finance and Policy.

After months of staff analysis, board deliberations and input from interested constituents, several program changes were instituted for the benefit year beginning on July 1, 2008. These were part of the first program reprocurement between the Health Connector and the Medicaid Managed Care Organizations (MMCOs) that offer Commonwealth Care plans.

These adjustments keep co-pays closer to the cost of co-pays for employer-sponsored insurance plans and are intended to help prevent crowd-out and ensure the future viability of the program.

Commonwealth Care plans are currently offered by:

- Boston Medical Center (BMC) HealthNet Plan
- Fallon Community Health Plan
- Neighborhood Health Plan
- Network Health

Having health insurance doesn't necessarily rank high on a twenty-something's priority list.

Lifelong Norwood resident Jaclyn Michalos knows that first-hand. An avid runner and former captain of her college field hockey team, she had other things to do.

"Plus, it was really expensive," Jaclyn said.

But Commonwealth Care put health insurance within her reach … just in time, because in 2007 Jaclyn was diagnosed with breast cancer.

"If I didn't have health insurance, I would never have made an appointment with my doctor because of the cost. The cancer would have spread and I would not be alive today to tell you my story."

It's been more than a year since that diagnosis and Jaclyn is now cancer-free. Not only is she back at her regular waitressing job, but in August she returned to Norwood High School to once again patrol the sidelines as head coach of the junior varsity field hockey team. And this spring, she took part in the two-day, 40-mile Avon walk for breast cancer.

"I want to tell people my age that health insurance is the most important thing you could ever have. People have insurance for their cars, but too many ignore health insurance. Having health insurance saved my life."

In addition to being cancer-free, Jaclyn has no medical debt.

"It's scary how much everything costs. My parents told me they would have taken out a second mortgage to pay my bills if I didn't have health insurance because I have no money. I'm glad that didn't happen to them."

At 6-foot-5 inches and 225 pounds, Andrew Herlihy of Malden is a force to be reckoned with on the basketball court when he's not mountain biking, hiking or skiing. He also has to be on top of his game running after-school and summer camp programs for kids.

"I have to be very active with them, whether it's kneeling down to get to their level, talking with them, or playing in the gym," said the 25-year-old Stonehill College graduate.

Unfortunately, he spent a stint on the disabled list when he injured his knee and didn't go to the doctor because he couldn't afford it. Instead, he says, he spent four months in "extreme pain."

It wasn't until after that injury that he saw a Health Connector ad on the subway and decided to purchase a Commonwealth Choice Young Adult Plan.

"I'd been putting it off, but I knew I needed it," Andrew said.

Soon after that, he was playing basketball again when he tore the meniscus in the previously injured knee. This time his insurance card gave him a speedier road to recovery. He was able to see a specialist, was fitted for an immobilizer, underwent physical therapy and was back to work and on the basketball court.

"Before I hurt my knee, I was one of those people who thought I didn't need health insurance. It's a miniscule price to pay to ensure that you can continue with your every day activities. My insurance helped get me back to the basketball court and doing what I love doing more than anything - working with kids."

Commony
Empowering C

Commonwealth Choice provides a marketplace in which consumers can shop and compare well-known commercial health plans in Massachusetts. Tools and assistance are available so that consumers can choose the plan that is right for them. As of August 2008, more than 18,000 Massachusetts residents have found health coverage through Commonwealth Choice.

Commonwealth Choice was created through the Health Care Reform law to provide consumers with information and choice in the private market for health insurance. Prior to the program's creation, it was difficult for individual consumers to compare plans and, unlike large employer groups, they had little standing to push for greater value or better choices.

Through Commonwealth Choice, the Health Connector negotiates directly with the health plans. Offerings that meet standards for affordability and value receive the Health Connector's Seal of Approval before they are offered to consumers. Consumers can then shop, compare and enroll by phone or online using the Health Connector's award-winning website, MAhealthconnector.org.

The Health Connector has reduced cost, and has held down premium increases. New plan offerings in the second year of Commonwealth Choice had an average premium increase of 5 % - progress in a market that had characteristically experienced double-digit increases.

wealth Choice Consumers

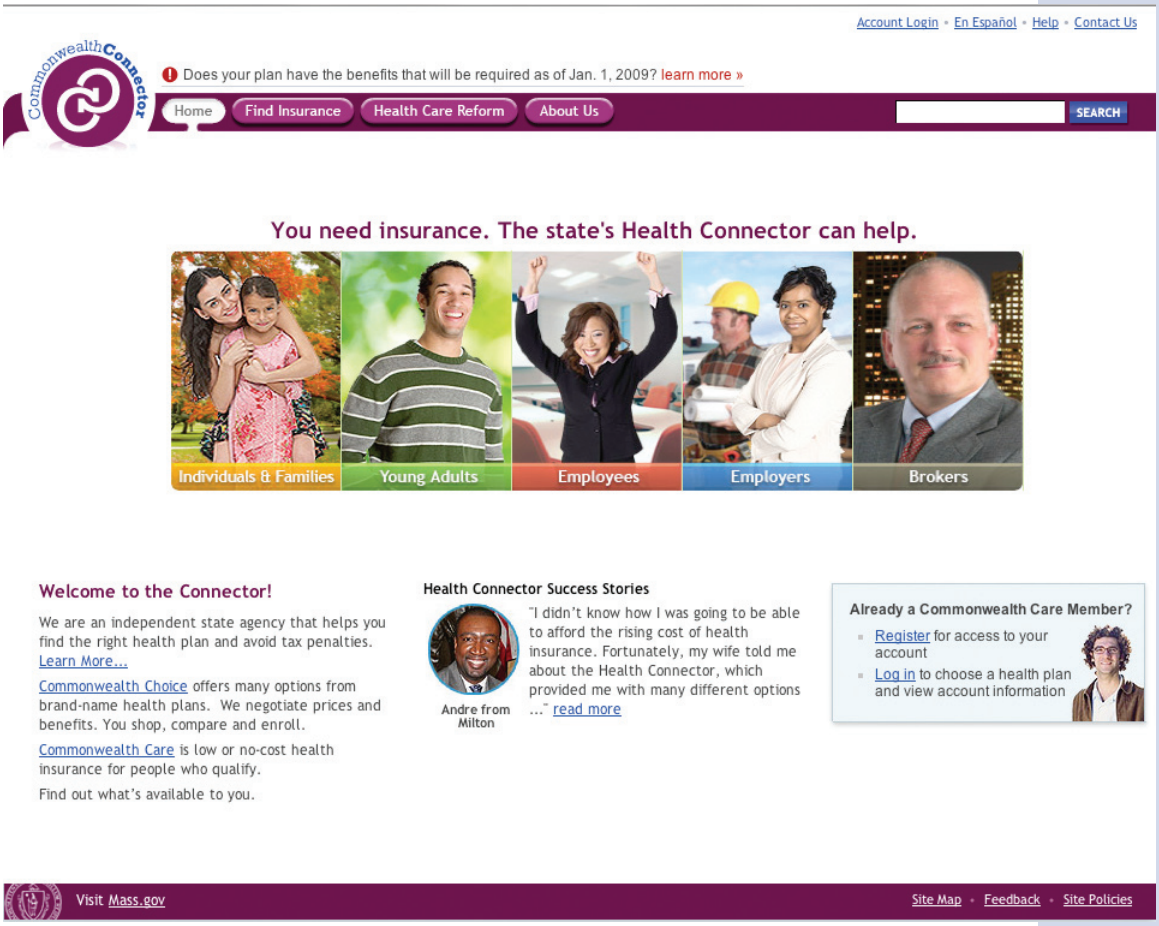
***According to data** on non-group enrollment from the Division of Health Care Finance and Policy, Commonwealth Choice accounted for 50 % of the total growth in the non-group (or individual) market for insurance in Massachusetts from its inception to March 31, 2008.*

Commonwealth Choice provides health insurance through three main channels:

Direct-to-consumer plans. Launched in May 2007, a complete consumer shopping experience – online or by phone – gives Massachusetts consumers their first-ever, one-stop-shopping opportunity to compare health plans on price and benefits and to enroll.

To help consumers sort their options, plans are organized into Gold, Silver and Bronze tiers, based on prices and benefits. An additional tier of options is available for 18- to 26-year-olds, the Young Adult Plans (YAPs). YAPs were authorized by the Health Care Reform law to help address a well-documented disparity: young adults make up a disproportionately large share of the uninsured, in large part because they use relatively little medical care and earn less than older adults. The marketplace needed new options to respond to the way young adults perceived their health risks while offering them access to care, should anything go wrong. Commonwealth Choice YAPs provide lower premiums, a choice of plans with and without prescription drug

Below is the home page for the Health Connector web site.



coverage, and benefits to better reflect price sensitivity. YAPs are the choice of 28% of all Commonwealth Choice subscribers.

Commonwealth Choice Voluntary Plan for Employers.
The law requires employers with 11 or more full-time equivalent employees to allow certain employees to pay for health insurance before state and federal taxes are applied to their paychecks. Many employers now need to offer these tax-free, "Section 125 Plan" savings to certain employees, even if those employees do not qualify for the employer's subsidized health benefits.

*Once a consumer selects a tier, the Health Connector's web site typically presents three to five plan options.**

Compare Selected Plans

Tier	Plan	Premium*	Deductible	Co-Payments			Hospital Stay	Doctors You Can See	Choose Plan
				Doctor	RX	ER			
B	☐ ***Neighborhood Health Plan*** NHPThree Select	**$193.19**	$2,000/$4,000	$25	$15 after Rx deductible / 50% co-insurance after Rx deductible / 50% co-insurance after Rx deductible	$100 after deductible	20% co-insurance after deductible	Find Doctor	View Plan
B	☐ ***Tufts Health Plan*** Advantage HMO Select 2000 (Limited choice of doctors & hospitals)	**$245.05**	$2,000/$4,000	$40	$20 after Rx deductible / $50 after Rx deductible / $75 after Rx deductible	$200	$0 after deductible	Find Doctor	View Plan
B	☐ ***Fallon Community Health Plan*** FCHP Select Care	**$254.00**	$2,000/$4,000	$25	$10 / $50 / $100	$100	$500 per admission after deductible	Find Doctor	View Plan
B	☐ ***Harvard Pilgrim Health Care*** Harvard Pilgrim Core Coverage 1750	**$277.72**	$1,750/$3,500	$25 copay up to 3 medical care office visits per individual (or 6 per family); next visits are subject to the deductible; then 20% co-insurance thereafter	$15 / 50% co-insurance after Rx deductible / 50% co-insurance after Rx deductible	$250	20% co-insurance after deductible	Find Doctor	View Plan
B	☐ ***Blue Cross Blue Shield of Massachusetts*** HMO Blue Basic Value	**$288.73**	$250 per plan year/$500 per plan year	$25	$15 / 50% co-insurance after Rx deductible / 50% co-insurance after Rx deductible	$150	35% co-insurance after deductible	Find Doctor	View Plan

Compare Selected Plans

** Based on rates for a 37-year-old , average uninsured individual in Boston during August of 2008.*

The Commonwealth Choice Voluntary Plan lets eligible employees apply these tax-free savings of 28% to 48% to the purchase of a Commonwealth Choice plan, without an employer contribution. To date, approximately 3,000 Massachusetts employers offer this Commonwealth Choice option. Membership growth has been slow but steady and stands at more than 1,000, as of June 2008.

Commonwealth Choice Contributory Plan for Employers. When launched in the fall of 2008 for coverage to start Jan. 1, 2009, this program will offer a brand new way for small employers to offer health insurance benefits to their employees with an employer contribution toward the cost. Employers will compare the Commonwealth Choice plans, make a selection, and manage their costs by adjusting their contribution levels for employees and dependents. Once their choice is confirmed, employers will invite their employees to enroll. Employees will be able to enroll in the employer's plan of choice or apply the employer's contribution to another Commonwealth Choice plan.

Commonwealth Choice plans are currently offered by:

- Blue Cross Blue Shield of Massachusetts
- Fallon Community Health Plan
- Harvard Pilgrim Health Care
- Health New England
- Neighborhood Health Plan
- Tufts Health Plan

When Kay and Eugene Winakor retired to old Cape Cod last year, they were fortunate they didn't have to bring their old health insurance plan with them.

As a small business owner in Connecticut, Eugene was eligible to continue his health coverage through COBRA when he and his wife took up permanent residence in the South Yarmouth home they had owned for many years.

"This alternative would have cost us over $2,000 a month and we would have to belong to a plan that may not have protected our needs," said Kay.

The Winakors were delighted when they discovered the comprehensive Commonwealth Choice options that were available through the Health Connector. And they were thrilled that the plan they selected saves them more than $600 a month.

"The state's Health Connector is a good program," said Kay. "Most health care costs are extreme, but the Connector makes the effort to help us."

Health Reform has been implemented as a cooperative effort of numerous state agencies, all of whom share in its success. We want to thank and acknowledge them.

Executive Office for Administration and Finance
Department of Revenue
Executive Office of Health and Human Services
MassHealth
Division of Health Care Finance and Policy
Department of Public Health
Division of Insurance
Division of Unemployment Assistance
Group Insurance Commission
Massachusetts Board of Higher Education
Registry of Motor Vehicles
MBTA

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Helping Your Employees **Connect to Good Health**

Section 125 Plan Handbook for Employers

CommonwealthConnector

Version 2.0 (July 1, 2007)

This handbook can also be found on the Health Connector's website at www.MAhealthconnector.org

Table of Contents

I. Introduction

The goal of the Mass Health Care Reform Law is to increase access to medical (health) care coverage for residents of the Commonwealth. The guiding principle behind this reform is one of shared responsibility: individuals, employers, health plans and state agencies all have new responsibilities under the law.

One of the primary employer responsibilities under the Mass Health Care Reform Law is the requirement that employers with 11 or more full-time equivalent employees adopt and maintain a Plan that satisfies both a) Section 125 of the Internal Revenue Code and b) regulations established by the Commonwealth Connector (the Health Connector). This requirement goes into effect on July 1, 2007.

The purpose of this handbook is to explain and help employers comply with these new requirements. We recommend that employers consult with their broker, consultant and/or attorney before adopting or amending their Section 125 Plan (Plan) to meet these requirements.

Following are some highlights of the new requirements:

- 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 Plan must offer eligible employees access to one or more health care coverage options to each eligible employee.
- Employers do not need to contribute to the cost of health care coverage options available under the Plan.
- While health care coverage options made available under the employer's Plan don't need to include those offered through the Health Connector, there are several advantages to doing so. These include:
  - Employees may select from several affordable Commonwealth Choice health coverage options offered by Blue Cross Blue Shield of Mass, Fallon Community Health Plan, Harvard Pilgrim Health Care, Health New England, Neighborhood Health Plan and Tufts Health Plan
  - All Commonwealth Choice options have earned the Health Connector's Seal of Approval and comply with the Mass Health Reform Law
  - It's easy for members to enroll in Commonwealth Choice
  - The Commonwealth Choice premium billing process is streamlined for the employer
- Employers may exclude certain classes of employees from the Plan.
- Employers may include the following waiting periods:
  - Up to 2 months if the employer does not contribute (Voluntary Plan)
  - Equal to health care coverage waiting period if the employer contributes
- A copy of the Plan must be filed with the Health Connector. Information on how an employer can meet this requirement will be available on the Health Connector's website at a later date. Filing is required by October 1, 2007, but no documents can be accepted before September 1st.

The Section 125 Plan requirements are explained in more detail in the following sections of this Handbook. Employers who meet these requirements are exempt from the Free Rider Surcharge provision of the Mass Health Care Reform Law.

II. What is a Section 125 Plan?

Under federal tax law, a Section 125 Plan is a written plan that permits employees to choose between receiving cash (the employee's normal cash wages) and certain qualified benefits that can be paid for on a pre-tax basis by employees.

A Section 125 Plan may be established by any of the following:

- C Corporations
- Partnerships
- S Corporations
- Limited Liability Corporations
- Sole Proprietorships
- Professional Corporations
- Non-Profit Organizations

IRS regulations state that self-employed individuals are not employees. Therefore, self-employed individuals may establish but may not participate in a Section 125 Plan, although spouses or other family members who are employees may participate in some cases.

A Section 125 "premium-only plan" allows an employee to pay their health care coverage premiums on a pre-tax basis, thus lowering their taxable income and, consequently, their tax liability.

An employee's election to pay for benefits on a pre-tax basis is made by entering into a salary reduction agreement with the employer. Under a salary reduction agreement, an employee elects to reduce his/her compensation by a stated amount on a pre-tax basis and those amounts are considered by the IRS to be employer contributions. In effect, it is as if the employee has given up the right to receive that part of his/her salary before actually becoming entitled to it. Therefore, the employee's salary reduction contributions are not actually received by the employee, and thus, are neither considered wages for state and federal income tax purposes nor subject to FICA withholding.

It is important to note that, under a Section 125 Plan, health care coverage premiums may be paid entirely by employee salary reduction – employer contributions are not required.

III. What are the Benefits of a Section 125 Plan?

There are several benefits to maintaining a Section 125 Plan:

Pre-tax savings for the employer and its employees

As mentioned above, an employee who pays his/her health care coverage premiums on a pre-tax basis realizes a savings on state income, federal income and federal FICA taxes. This tax savings could amount to as much as 40% of the cost of health care coverage. The employer also realizes FICA withholding tax savings for each participating employee.

The example below illustrates the annual tax savings realized by an employee in Massachusetts with adjusted gross income of $50,000 who participates in his/her employer's Plan:

	w/o Plan	with Plan
Adjusted Gross Income	$50,000	$50,000
Annual Pre-tax Health Care Coverage Contribution	$0	$ 2,100
Taxable Income	$50,000	$47,900
Estimated Taxes	$12,676	$11,880
Annual After-Tax Health Care Coverage Contribution	$ 2,100	$0
Net Take Home Pay	$ 35,224	$36,020

In this example, the employee achieves annual tax savings of $796 and his/her employer saves $161 in annual FICA taxes.

Increased Morale

Allowing employees to pay their health care coverage premiums on a pre-tax basis increases their take-home pay, effectively giving them a pay raise with no added costs to their employer. Any pay raise is appreciated by employees, whose boosted morale can increase productivity.

Avoidance of Free Rider Surcharge

Under the Mass Health Care Reform Law, the Free Rider Surcharge is a penalty that may be charged to employers who do not comply with the Section 125 Plan requirement. Additional information on the Free Rider Surcharge may be found on the Health Connector's website at www.MAhealthconnector.org.

IV. How to Meet Federal and State Section 125 Plan Requirements

Employers with 11 or more full-time equivalent employees are required to adopt and maintain a Section 125 Plan that meets the requirements of both federal law and Mass Health Care Reform law (and subsequent regulations published by the Health Connector).

Requirements under Federal Law

Section 125 of the Internal Revenue Code requires a written Plan Document that must be adopted by the employer on or before the date the Plan is effective.

The Plan Document must contain the following:

- Description of the benefits that may be elected
- Eligibility rules
- Method, timing and irrevocability of participant elections
- Manner of any employer contribution
- Maximum amount of employer and employee contributions under the plan
- The Plan Year

Federal law does not contain any specifics about how to adopt a Plan. Employers that are corporations should adopt the Plan by a resolution of its board of directors (or an authorized representative of the board). Other types of employers may use a certificate of adoption. Once adopted, the written Plan Document is usually signed by an officer or other individual who has authority to sign benefit plan documents.

There is no requirement to file the Plan Document with the IRS or any other federal agency. Additionally, the IRS currently does not issue rulings or determination letters indicating whether an employer's Plan satisfies the federal Section 125 Cafeteria Plan requirements.

Requirements under State Law and Health Connector Regulations

For purposes of Mass Health Care Reform, the Health Connector regulations provide that a Section 125 Plan must be, at minimum, a premium-only plan offering access to one or more health coverage options in lieu of regular cash compensation. It must meet federal requirements as outlined above. It need not follow a particular Plan Year.

Section 125 Plans that function as flexible spending account only plans, or as premium-only plans offering access to benefit options that do not include access to any health care coverage options, will not satisfy these requirements.

Health Connector regulations require employers to file with the Health Connector Plan Documents covering participants working at Massachusetts locations (guidance on timing and process to be issued by the Health Connector at a later date; filing is required by October 1, 2007, but no documents can be accepted before September 1, 2007).

Health Connector regulations permit Plans to cover employees of two or more employers if the employers are affiliated with or related to one another. In such an instance, the Plan Document should clearly identify all participating employers.

Under the Health Connector regulations, one or more of the following classes of employees may be specifically excluded from eligibility to participate in an employer's Section 125 Plan:

- Employees who are less than 18 years of age
- Temporary Employees
- Part-time Employees working, on average, fewer than 64 hours per month for an Employer (information on how to determine the number of hours an employee works can be found in Appendix A-2)
- 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 (as defined in M.G.L. c. 149, Section 152A) and who earn, on average, less than $400 in monthly payroll wages; tips are not included in monthly payroll wages for this purpose
- Student Employees who are employed as interns or as cooperative education student workers
- Seasonal Employees who are international workers with either a U.S. J-1 student visa, or a U.S. H2B visa and who are also enrolled in travel health insurance

V. Employee Election and Participation Guidelines

Generally, once an employee has elected to participate in his/her employer's Section 125 Plan, the election cannot be revoked during the Plan Year even if the revocation relates only to the remaining portion of the plan year. However, a Plan may permit a participating employee to revoke an existing election and make a new election for the remaining portion of the plan year if a "change in status" occurs and the election change is consistent with the change in status. "Change in status" events can include:

- A change in the employee's legal marital status
- A change in the employee's number of dependents
- A covered dependent satisfying or ceasing to satisfy the eligibility requirements for coverage
- A change in the employment status of the employee, spouse or dependent
- A change in the place of residence of the employee, spouse or dependent

Mid-year election changes may be permitted by a Plan, as long as they result from:

- Electing or canceling health coverage for a dependent child related to a Qualified Medical Child Support Order ("QMCSO")
- Becoming covered by, or losing coverage under, Medicare or Medicaid
- Experiencing significant cost or coverage changes
- Elections made by spouse or dependent under another employer's plan, or
- Special enrollment rights under HIPAA

VI. What is Commonwealth Choice?

Affordable Choice, Comprehensive Coverage

The Health Connector was created to help connect employers and their employees with a choice of good, affordable health care coverage options and the tools to help employees choose the option that is right for them. Health care coverage options from six health plans have earned the Health Connector Seal of Approval. These options, all of which comply with the Mass Health Care Reform requirements, are available to individuals (directly, whether or not premiums are paid through an employer's Section 125 Plan) and small businesses for effective dates beginning July 1, 2007 under the name Commonwealth Choice. Commonwealth Choice options will be available to small businesses on a contributory basis at a later date.

Commonwealth Choice health care coverage options are available from Blue Cross Blue Shield of Mass, Fallon Community Health Plan, Harvard Pilgrim Health Care, Health New England, Neighborhood Health Plan and Tufts Health Plan. Options vary by price and cost sharing, but all offer comprehensive coverage including inpatient and outpatient medical care, emergency care, mental health care and substance abuse services, rehabilitation services, hospice and vision care. Pharmacy coverage options are also available.

Simplified Administration

Commonwealth Choice coverage is available for effective dates on or after July 1. Members may select and enroll in Commonwealth Choice directly with the Health Connector via telephone, the Health Connector's website, mail, fax or in person. As mentioned earlier, while health care coverage options made available under the employer's Section 125 Plan don't need to include those offered through the Health Connector, there are several advantages to doing so.

Employers may allow their employees to access Commonwealth Choice coverage through their Section 125 Plan on a voluntary basis (i.e. with no employer endorsement or contribution). For employees participating in an employer's Section 125 plan, premiums will be deducted on a pre-tax basis by the employer and remitted monthly to the Health Connector.

Additional information on available Commonwealth Choice plans (including benefits, premiums, the enrollment process and key contacts) are available on the Health Connector's website at www.MAhealthconnector.org.

VII. Frequently Asked Questions

What is a Section 125 Plan?

It is a benefit plan that employers may offer under federal tax law that allows employees to pay for health care coverage (and other qualified benefits) on a pre-tax basis. Participating employees' premium contributions are not subject to state, federal or federal FICA withholding taxes. The resulting tax savings could be as much as 40% of the premium cost. Employers also save on FICA taxes.

Am I required to offer one?

Under the Mass Health Care Reform Law (Mass Law), employers with 11 or more full-time equivalent employees who worked for more than 30 days must offer one. Full-time equivalent is determined by:

- Calculating the total payroll hours for all of your employees during the 12 months beginning on April 1, 2006 (2000 hour maximum for any one employee)
- Dividing by 2,000

For more information, see the Mass Health Care Reform Section 125 Plan Regulations.

What types of employers may establish a Section 125 Plan?

Section 125 Plans are available to:

- C Corporations
- Partnerships
- S Corporations
- Limited Liability Corporations
- Sole Proprietorships
- Professional Corporations
- Non Profit Organizations

What is a Premium-Only Plan?

Under federal law, a range of benefits may be offered through a Section 125 Plan. A premium-only plan is a very basic plan option that employers may offer. It allows eligible employees to contribute to the cost of health care coverage on a pre-tax basis. A premium-only plan provides no other benefits to employees, and is the minimum Plan allowed under the Health Care Reform regulations.

How do employers establish Section 125 Plans?

Employers should consult their broker, benefits lawyer, payroll vendor and/or accountant and are encouraged to use the sample documents, forms and tools offered by the Health Connector.

When must a Section 125 Plan Document be adopted?

Employers must adopt the written Plan Document on or before the effective date of the Plan.

May employers exclude any classes of employees from their Section 125 Plan and still comply with the Mass Health Care Reform Law?

Yes. Employers may exclude one or more of the following classes of employees:

- Employees under age 18
- Temporary employees
- Part-time employees who average fewer than 64 hours per month
- Employees for whom the employer is required to contribute to a Multiemployer Health Benefit Plan based on their employment
- Wait staff, service employees or service bartenders (as defined in M.G.L. c. 149, Section 152A) who earn, on average, less than $400 in monthly payroll wages; tips are not included in monthly payroll wages for this purpose
- Students who are employed as interns or as cooperative education student workers
- Seasonal Employees under a U.S. J-1 student visa or a U.S. H2B visa, and who are enrolled in travel health insurance

Under a Section 125 Plan, how do employees elect to pay for health care coverage on a pre-tax basis?

An employee must enter into a salary reduction agreement with their employer, confirming that he/she wishes to pay for health care coverage on a pre-tax basis.

When do employees enroll in the Section 125 Plan?

Federal regulations say that employee elections must be made:

- during an annual open enrollment period
- within a specified period of time following date of hire, or
- the date an employee first becomes eligible under the plan

Is an employee required to participate in his/her employer's Section 125 Plan?

No. However, if an employee chooses not to participate any premium contributions they make toward health care coverage will be on an after-tax basis.

Are employers required to contribute toward the coverage offered through its Section 125 Plan?

No. Contributions may be made solely by the employee. But employers may want to see if it makes sense to offer a contribution, based on other requirements of the Health Reform Law.

What happens if an eligible employee works for two or more employers?

Employees may only participate in one Section 125 Plan. Employees working for two or more employers must select one employer's Plan.

Are employers that currently offer access to health care coverage through a Section 125 Plan required to establish a separate Plan for employees who are not currently eligible?

These employers are not required to establish a second Plan, but may now need to offer a Plan to new classes of employees. A separate plan for new classes of employees may make administrative or legal sense for some employers. Employers should consult with their tax or legal advisor.

Must employers adopt their own Section 125 Plan if they participate in the Plan of a parent, subsidiary or affiliated company?

No. The Mass Law allows Plans to cover employees of two or more employers if those employers are affiliated or related. The Plan Document should clearly identify all participating employers.

Must employers file Section 125 Plan Documents with the IRS?

No.

Which agency is responsible for the Section 125 Plan requirement under Mass Health Care Reform?

The Commonwealth Health Insurance Connector Authority (the Health Connector). Section 125 Plan rules and regulations established by the Health Connector are separate from, and in addition to, federal Section 125 Plan rules and regulations.

Must employers file Section 125 Plan Documents with the Commonwealth?

Yes. The Mass Law requires employers with employees working at Massachusetts locations to file their Plan Document with the Health Connector. Multi-state and/or international employers with Massachusetts locations should file only those Plan Documents covering participants working at Massachusetts locations (guidance on timing and process to be issued by the Health Connector at a later date; filing is required by October 1, 2007, but no documents can be accepted before September 1, 2007).

Do the Mass Law regulations require Section 125 Plans to follow a particular plan year?

No.

Under the Mass Law, are employers that pay 100% of the monthly cost for health care coverage for all employees required to offer a Section 125 Plan?

No.

How are premiums collected from participating employees who purchase health care coverage through the Health Connector?

Employers will withhold contributions from employee paychecks and remit contributions monthly to the Health Connector. The Health Connector tracks those employees through a census of participating employees submitted by the employer.

Which employees should be listed on the census?

Only those employees who are eligible to purchase Commonwealth Choice coverage through the employer's Section 125 Plan should be included.

What if an employee's earnings can't cover a premium payment?

The employer is not responsible for any shortfall amount. The employee must make immediate arrangements to pay any shortfall on an after-tax basis in accordance with procedures specified by the employer. For example, some employers may choose to take the shortfall from the employee and submit it to the Health Connector. Others may direct the employee to send a personal check directly to the Health Connector to cover the shortfall.

Appendix A1 - Mass Health Care Reform Section 125 Cafeteria Plan Regulations – published 6/29/07

Section 4.01 Authority

956 CMR 4.00 is promulgated in accordance with the authority granted to the Connector by M.G.L. c. 176Q, §16.

Section 4.02 Purpose

The purpose of 956 CMR 4.00 is to implement the provisions of M.G.L. c. 151F, which requires Employers with 11 or more Employees to (1) establish and maintain a Section 125 Cafeteria Plan in accordance with the rules and regulations promulgated by the Connector, and (2) file a copy of the Section 125 Cafeteria Plan with the Connector.

Section 4.03 Scope

956 CMR 4.00 contains the Connector's regulations governing the requirements of M.G.L. c. 151F. These regulations apply to all Employers with a total of 11 or more Employees at all locations within the Commonwealth of Massachusetts, regardless of whether any underlying medical care coverage accessed through a Section 125 Cafeteria Plan is maintained on an insured or self-insured basis, purchased on an individual or group basis, or provided through the Connector or through another distribution channel unrelated to the Connector.

Section 4.04 Definitions

As used in 956 CMR 4.00, unless the context otherwise requires, terms have the following meanings:

Client Company. A person, association, partnership, corporation or other entity that is a co-Employer of workers provided by an Employee Leasing Company pursuant to a contract.

Connector. The Commonwealth Health Insurance Connector established under M.G.L. c. 176Q.

Employee. Any individual employed by any Employer at a Massachusetts location, whether or not the individual is a Massachusetts resident.

Employee Leasing Company. 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.

Employer. An individual, partnership, association, corporation or other legal entity, or any two or more of the foregoing engaged in a joint enterprise, and including the legal representatives of a deceased employer, or the receiver or trustee of an individual, partnership, association, corporation or other legal entity, employing employees. Other legal entitities shall include, without limitation, the commonwealth, its instrumentalities, political subdivisions, an instrumentality of a political subdivision, including municipal hospitals, municipal electric companies, municipal water companies, regional school districts and any other instrumentalities as are financially independent and are created by statute.

Notwithstanding the preceding paragraph to the contrary, the owner of a dwelling house having not more than 3 apartments and who resides therein, or the occupant of a dwelling house of another who employs persons to do maintenance, construction or repair work on such dwelling house or on the grounds or buildings appurtenant thereto shall not because of such employment be deemed to be an employer. Further, the term "employer" shall neither include nonprofit entities, as defined by the Internal Revenue Code, which are exclusively staffed by volunteers, nor include sole proprietors.

Independent Contractor**.** An individual that provides services not deemed to be employment under M.G.L. c. 151A, § 2 because:

> (a) such individual has been and will continue to be free from control and direction in connection with the performance of such services, both under his contract for the performance of service and in fact; and
>
> (b) such service is performed either outside the usual course of the business for which the service is performed or is performed outside of all the places of business of the enterprise for which the service is performed; and
>
> (c) Such individual is customarily engaged in an independently established trade, occupation, profession or business of the same nature as that involved in the service performed.

Multiemployer Health Benefit Plan. A health benefit plan to which more than one Employer is required to contribute, which is maintained pursuant to one or more collective bargaining agreements between one or more employee organizations and more than one Employer, and there is

evidence that such Employer contributions to the Multiemployer Health Benefit Plan were the subject of good faith bargaining between such employee representatives and such Employers.

Seasonal Employee. An Employee who is a seasonal employee that works for an Employer that is a seasonal employer, as such terms are defined in M.G.L. c. 151A, section 1.

Section 125 Cafeteria Plan. A cafeteria plan that meets the requirements of Title 26, Subtitle A, Chapter 1, Subchapter B, Part III, Section 125 of the Internal Revenue Code.

Temporary Employee. An individual that works for an Employer on either a full or part time basis; whose employment is explicitly temporary in nature and does not exceed 12 consecutive weeks during the period from October 1 through September 30.

Section 4.05 Employers Subject to Chapter 151F

(1) General. An Employer is subject to the M.G.L. c. 151F requirement to adopt and maintain a Section 125 Cafeteria Plan in accordance with the rules of the Connector on and after the date, determined in accordance with 956 CMR 4.05(3), the Employer becomes a 151F Employer as determined in accordance with 956 CMR 4.05(2).

(2) 151F Employer. An Employer with 11 or more Employees during the applicable determination period, as determined in accordance with 956 CMR 4.05(3) shall become a Chapter 151F Employer as of the date set forth in 956 CMR 4.05(3).

(a) Number of Employees. An Employer has 11 or more Employees if the sum of total payroll hours for all Employees during the applicable determination period divided by 2,000 is greater than or equal to 11. In calculating total payroll hours:

1. For each Employee with more than 2000 payroll hours for the Employer, the Employer shall include 2000 payroll hours.

2. Payroll hours includes all hours for which an Employer paid wages as defined in M.G.L. c. 151A, section 1(s) to an Employee including, by way of example and not by way of limitation, regular, vacation, sick, paid Federal Medical Leave of Absence, short term disability, long term disability, overtime and holiday payroll hours.

3. An Employer who is determined to be a successor under M.G.L. c. 151A shall include the payroll hours of the predecessor's Employees during the applicable determination period.

(b) Employees. For purposes of this 956 CMR 4.05, Employees include, by way of example and not by way of limitation, full-time Employees, part-time Employees, Temporary Employees, and Seasonal Employees, regardless of whether his/her Employer is signatory to or obligated under a negotiated, bona fide collective bargaining agreement between such Employer and bona fide Employee representatives that governs the employment conditions of the Employee. Employees shall also include individuals who are considered self-employed for benefit plan purposes under Internal Revenue Code Section 401(c), but shall not include Independent Contractors.

(c) Multi-State Employer. A multi-state Employer with Massachusetts locations shall include all Employees employed at all Massachusetts locations in calculating total payroll hours.

(d) Certain Employee Leasing Arrangements. If and to the extent there is a co-employment arrangement between a Client Company and an Employee Leasing Company, the Client Company is the Employer for purposes of M.G.L. c. 151F with respect to those Employees covered under the co-employment arrangement. In the event the Client Company is determined to be a 151F Employer in accordance with 956 CMR 4.05(2), nothing in this 956 CMR 4.00 prohibits the Client Company from contractually allocating to the Employee Leasing Company the responsibility to adopt and/or maintain a Section 125 Cafeteria Plan for the benefit of the co-employed Employees, in accordance with 956 CMR 4.06, and to comply with the filing requirements in 956 CMR 4.07. However, if and to the extent that the Employee Leasing Company fails to comply with any such responsibilities contractually allocated to it, then the Client Company continues to have responsibility for compliance with this 956 CMR 4.00.

(e) Employers Providing Noncontributory Medical Coverage. Notwithstanding anything in this 956 CMR 4.05 to the contrary, an Employer will not be considered a 151F Employer if the Employer provides medical care coverage to and pays the full monthly cost of such medical care coverage (both individual coverage AND any dependent coverage to the extent elected by the Employee) for all of its Employees who are not otherwise excludable from a Section 125 Cafeteria Plan in accordance with 956 CMR 4.06(3)(b)4. This 956 CMR 4.05(2)(e) shall cease to apply on the date the Employer ceases to provide medical care coverage to or ceases to pay the full monthly cost of that medical care coverage for all of its Employees who are not otherwise excludable from a Section 125 Cafeteria Plan in accordance with 956 CMR 4.06(3)(b)4) (the "cessation date"). The Employer shall then determine its status as a 151F Employer in accordance with this 956 CMR 4.05 beginning with the April 1 determination date coincident with or next following the cessation date. In no event shall any reference to the full monthly cost of medical care coverage in this 956 CMR 4.05(e) be construed to include any deductible, coinsurance, copayment or other cost-sharing amounts that are the responsibility of the Employee under the applicable medical care coverage.

3) Applicable Determination Period

(a) Initial Determination Period. The initial determination period shall be the 12 consecutive month period beginning April 1, 2006 and ending March 31, 2007. An Employer with 11 or more Employees during the initial determination period, as determined in accordance with 956 CMR 4.05(2), shall become a 151F Employer effective July 1, 2007.

(b) Subsequent Determination Periods. For those Employers who do not have 11 or more Employees during the initial determination period (or a subsequent determination period, as applicable), as determined in accordance with 956 CMR 4.05(2), October 1, 2007 and each October 1 thereafter will be considered a new determination date for any Employer with less than 11 Employees during the preceding determination period. The applicable subsequent determination period for each October 1 determination date shall be the 12 consecutive month period ending on the September 30 immediately preceding the October 1 determination date. An Employer with 11 or more Employees during a subsequent determination period, as determined

in accordance with 956 CMR 4.05(2), shall become a 151F Employer effective on the first day of January following the corresponding October 1 determination date.

Section 4.06 Adoption and Maintenance of Section 125 Cafeteria Plan

(1) General. Pursuant to M.G.L. c. 151F, a 151F Employer is required to adopt and maintain a Section 125 Cafeteria Plan in accordance with regulations and rules promulgated by the Connector. A Section 125 Cafeteria Plan must meet the requirements of 956 CMR 4.06(2) and (3) and must be adopted and maintained by the 151F Employer as described in 956 CMR 4.06(4) and (5) respectively. A 151F Employer shall not be in compliance with M.G.L. c. 151F if and to the extent its Section 125 Cafeteria Plan fails to satisfy this 956 CMR 4.06.

(2) Section 125 Cafeteria Plan Requirements. A Section 125 Cafeteria Plan must satisfy applicable Internal Revenue Code Section 125 requirements, any applicable U.S. Treasury Department rulings, regulations and guidance, as determined by the Internal Revenue Service, and shall include:

(a) Written Plan Document. A Section 125 Cafeteria Plan must consist of a written plan document containing at least the following six elements.

1. A specific description of each of the benefits available under the plan, including the periods during which the benefits are provided. The benefit description need not be self-contained. Benefits described in other separate written plans may be incorporated by reference into the plan document.
2. The plan's eligibility rules regarding participation.
3. The procedures governing participant elections under the plan, including the period during which elections may be made, the extent to which elections are irrevocable, and the periods with respect to which the elections are effective.
4. The manner in which Employer contributions may be made to the plan, such as by salary reduction agreement between the participant and Employer or by non-elective Employer contributions to the plan.
5. The maximum amount of elective Employer contributions available to any participant under the plan either by stating the maximum dollar amount or maximum percentage of compensation that a participant may contribute, or by stating the method for determining the maximum amount or percentage.
6. The plan year on which the cafeteria plan operates.

(3) Connector Requirements. In addition, a Section 125 Cafeteria Plan must comply with the following minimum Connector requirements in order to comply with M.G.L. c. 151F:

(a) Premium Only Plan. A Section 125 Cafeteria Plan must, at a minimum, be a premium only plan offering access to one or more medical care coverage options to each eligible Employee in lieu of regular cash compensation.

1. Section 125 Cafeteria Plans that function as flexible spending account only plans, or as premium only plans offering access to benefit options that do not include access to any medical care coverage options will not satisfy this 956 CMR 4.06(3).

2. Flexible spending accounts are not required to be offered as a coverage option.

(b) Eligibility for Participation. In connection with a Section 125 Cafeteria Plan offered by a 151F Employer:

1. Employee eligibility requirements for participation in a Section 125 Cafeteria Plan of a 151F Employer (and the extent of such participation) shall be established by the applicable 151F Employer and shall be clearly set forth in its written Section 125 Cafeteria Plan document.
2. A 151F Employer may provide for an eligibility waiting period in its Section 125 Cafeteria Plan. Such a Section 125 Cafeteria Plan eligibility waiting period will be considered in compliance with M.G.L. c. 151F if the eligibility waiting period:
   a. corresponds with (and does not exceed) the eligibility waiting period for enrollment in the applicable medical care coverage option(s) available to the eligible Employee under the Section 125 Cafeteria Plan provided the 151F Employer makes contributions toward such coverage; or
   b. does not exceed 2 months (e.g., March 1 to May 1; or March 20 to May 20 is considered two months) if the 151F Employer makes no contribution toward the applicable medical care coverage option(s) available to the eligible Employee under the Section 125 Cafeteria Plan.

   Notwithstanding the foregoing to the contrary, those Employers that have 151F status as of July 1, 2007 may provide for a special initial eligibility waiting period in a Section 125 Cafeteria Plan for those eligible Employees who are employed on July 1, 2007 that may extend to no later than September 1, 2007.
3. An eligible Employee must be offered participation in the Section 125 Cafeteria Plan during any applicable election periods provided for in the written Section 125 Cafeteria Plan document, without regard to whether the eligible Employee was previously eligible or had previously waived participation in the Section 125 Cafeteria Plan during any prior election period.
4. Notwithstanding anything in this 956 CMR 4.00 to the contrary, a 151F Employer may specifically exclude from eligibility to participate in its Section 125 Cafeteria Plan the following classes of Employees without being considered not in compliance with M.G.L. c. 151F with respect to such Employees:
   a. Employees who are less than 18 years of age
   b. Temporary Employees
   c. Part-time Employees working, on average, fewer than 64 hours per month for an Employer
   d. Employees who are considered wait staff, service employees or service bartenders (as defined in M.G.L. c. 149, section 152A) and who earn, on average, less than $400 in monthly payroll wages
   e. Student Employees who are employed as interns or as cooperative education student workers

f. Employees whose Employer is required to contribute to a Multiemployer Health Benefit Plan based on their employment
g. 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.

(c) No Employer Contributions Required. All contributions made in connection with medical care coverage options offered under a Section 125 Cafeteria Plan may be made solely by Employee salary reduction. Non-elective Employer contributions to the Section 125 Cafeteria Plan are not required.

(d) Plan Document Configuration. The Section 125 Cafeteria Plan document may be a separate, stand-alone document or combined/consolidated with other employer-provided plans. A 151F Employer may utilize more than one Section 125 Cafeteria Plan document to provide its Employees with access to medical care coverage options, including a plan established solely for Employees not otherwise eligible for the 151F Employer's subsidized medical care coverage options.

(e) Affiliated/Participating Employers. Nothing in this regulation is intended to restrict Section 125 Cafeteria Plan documents from covering Employees of two or more 151F Employers to the extent the Employers are affiliated/related to one another. The plan documentation should clearly identify all participating employers.

(4) Plan Adoption. Each 151F Employer shall take such actions as it deems necessary or appropriate to adopt its Section 125 Cafeteria Plan(s) in accordance with its own internal governance procedures and with applicable law, regardless of whether the Section 125 Cafeteria Plan is intended to be a newly established plan, a plan amendment to an existing plan or an amended and restated plan.

(a) Plan Effective Date. The written plan documentation must clearly state the effective date of the Section 125 Cafeteria Plan (or, if applicable, the effective date of any subsequent plan amendment or restatement intended to conform the Section 125 Cafeteria Plan to M.G.L. c. 151F), which shall be no later than the date the Employer became a 151F Employer, as determined in accordance with 956 CMR 4.05.

(b) Affiliated/Participating Employers. Each 151F Employer who is a participating Employer in an affiliated/related Employer's Code Section 125 Cafeteria Plan shall take such actions as it deems necessary or appropriate to adopt such Section 125 Cafeteria Plan(s) in accordance with its own internal governance procedures and with applicable law.

(5) Plan Maintenance. A Section 151F Employer shall be deemed to maintain a Section 125 Cafeteria Plan as required by M.G.L. c. 151F if the plan meets the Cafeteria Plan requirements in 956 CMR 4.06(2), the Connector requirements in 956 CMR 4.06(3), has been adopted in accordance with 956 CMR 4.06(4), and has not been subsequently terminated by the 151F Employer.

Section 4.07 Filing Section 125 Cafeteria Plan Documents

(1) General. Pursuant to M.G.L. c. 151F, a 151F Employer is required to file a copy of its Section 125 Cafeteria Plan(s) with the Connector.

(2) Filing Requirements.

(a) Each 151F Employer shall submit a copy of its Section 125 Cafeteria Plan(s) to the Connector, or its designee, on or before the effective date of its 151F Employer status. Any Section 125 Cafeteria Plan maintained by a 151F Employer that is not available to any Employees employed at a Massachusetts location is not subject to the filing requirement and need not be submitted to the Connector.

(b) Each submission shall be in the form and manner specified by the Connector and shall include such other documentation related to the 151F Employer's Section 125 Cafeteria Plan as the Connector may from time to time require.

(c) An Employer must designate a responsible individual authorized to verify and certify the accuracy of the documentation submitted.

(d) The Connector may change the filing requirements, including specified forms and filing deadlines, by administrative bulletin.

Section 4.08 Other Provisions

(1) Compliance Enforcement. Compliance with M.G.L. c. 151F and this 956 CMR 4.00 will be enforced by the attorney general. Noncompliance may subject a 151F Employer to the Employer Surcharge for State-Funded Health Costs described in M.G.L. c. 118G and any regulations promulgated thereunder, as amended from time to time

(2) Consistency with Section 125. The Connector intends that these regulations neither be inconsistent with Internal Revenue Code Section 125, nor require any Employer to take any action that would violate Internal Revenue Code Section 125.

(3) No ERISA Plan. In general, a Section 125 Cafeteria Plan is not an ERISA welfare benefit plan and nothing in these regulations is intended to require any Employer to establish an ERISA welfare benefit plan.

(4) Administrative Information Bulletins. The Connector may issue administrative information bulletins to clarify policies, update administrative requirements and specify information and documentation necessary to implement 956 CMR 4.00.

(5) Severability. The provisions of 956 CMR 4.00 are severable. If any provision or the application of any provision is held to be invalid or unconstitutional, such invalidity shall not be construed to affect the validity or constitutionality of any remaining provisions of 956 CMR 4.00 or the application of such provisions.

REGULATORY AUTHORITY

956 CMR 4.00; M.G.L. c. 176Q.

Appendix A2 - Mass Health Care Reform Section 125 Cafeteria Plan Administrative Bulletin

Administrative Information Bulletin 03-07:
Guidance Regarding M.G.L. c. 151F, as implemented by 956 CMR 4.00

June 29, 2007

Pursuant to 956 CMR 4.08(4), the Commonwealth Health Insurance Connector Authority (the "Connector") is issuing this Administrative Information Bulletin ("Bulletin") to provide guidance in connection with the section 125 cafeteria plan requirement set forth in M.G.L. c. 151F and 956 CMR 4.00. The Bulletin provides (a) administrative information concerning the filing of employer-maintained section 125 cafeteria plan documents with the Connector under 956 CMR 4.07; and (b) clarification related to certain classes of employees that are excludable from participation in an employer's section 125 cafeteria plan in accordance with 956 CMR 4.06.

(1) Filing Section 125 Cafeteria Plan Documents

(a) Postponement of Filing Deadline. Pursuant to M.G.L. c. 151F and 956 CMR 4.07, an employer is required to file a copy of its section 125 cafeteria plan(s) with the Connector, or its designee, on or before the effective date of the employer's status as a 151F Employer. For employers with 11 or more full-time equivalent employees during the initial determination period ending March 31, 2007, who qualify as 151F Employers, the filing deadline has been set at July 1, 2007. In accordance with 956 CMR 4.07 (2)(c), by this administrative bulletin the Connector is postponing the filing deadline for those section 125 cafeteria plan documents due to be filed on or before July 1, 2007 until **October 1, 2007**. Further, the Connector will not accept section 125 cafeteria plan documents prior to September 1, 2007.

(b) Filing Upon Request of the Connector. During the period of postponement between July 1, 2007 and October 1, 2007, a 151F Employer shall, upon request of the Connector, submit a copy of its section 125 cafeteria plan(s) to the Connector in the time and manner specified by the Connector.

(2) Definition of Employee. An employee, as defined in 956 CMR 4.04, is revised as follows: An individual employed by any Employer at a Massachusetts location, whether or not the individual is a Massachusetts resident. **For purposes of counting the number of employees in 956 CMR 4.05(2), an employee referred to in 956 CMR 4.05(2)(b) shall not include an individual employed for less than one month.**

(3) Defining Excludable, Part-time Employees. In accordance with 956 CMR 4.06 (3)(b), a 151F Employer may, at its option, specifically exclude from eligibility to participate in its section 125 cafeteria plan one, none, or any combination of the specified employee classes and still be compliant with M.G.L. c. 151F with respect to such excluded employees. 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 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.

c. Example. Paul is hired as a part-time employee and commences employment on September 15, 2007. His employer's section 125 plan excludes from eligibility part-time employees working, on average, less than 64 hours per month. At the time of hire, Paul's employer reasonably anticipates that Paul will work an average of at least 65 hours per month; making Paul eligible for the employer's section 125 plan which operates on a July 1 fiscal year and facilitates the purchase of Connector seal of approval policies from the Connector on a pre- tax basis. Open enrollment for the section 125 plan will begin May 1, 2008 for the next plan year beginning July 1, 2008.
    - Assuming he is employed for the duration, Paul will be considered a new hire until April 30, 2008 (the later of X and Y in subparagraph b. above) and any election made by Paul when hired will remain in effect until the end of the plan year (June 30, 2008), regardless of actual hours worked per month during that period.
    - If Paul wishes to re-enroll for pre-tax benefits for the new plan year, his employer can redetermine his eligibility by averaging Paul's hours worked during the 180 days preceding May 1, 2008.

(4) Wait staff tips exclusion: Employers may exclude from participation in a Section 125 plan those employees who are considered wait staff, service employees or service bartenders (as defined in M.G.L. c. 149, section 152A) who earn, on average, less than $400 in monthly payroll wages. Employers should not include tips when calculating whether an individual's wages exceed $400 monthly for purposes of determining whether employees fall within this exclusion. Tips mean a sum of money, including any amount designated by a credit card patron, a gift or a gratuity, given as an acknowledgment of any service performed by a wait staff employee, service employee, or service bartender.

(5) 64 Hour Part-time Threshold. If an employer excludes part-time employees based on an hours per month classification, as permitted in 956 CMR 4.00, that employer may not exclude from eligibility part-time employees working, on average, 64 or more hours per month. An employer may, however, adopt an hourly threshold for part-time, excludable employees that fall bellows the standard of 64 hours per month (e.g., 32 hours per month).

This Administrative Bulletin takes effect immediately.

Appendix B1 – Sample Implementation Checklist

ABC Company
Cafeteria Plan

Check When Completed

1. Adoption Agreement – Section 125 Cafeteria Plan (including Schedules A, B, C & D) ❑
Complete in its entirety, sign and date no later than the effective date of the Plan.

2. Cafeteria Plan Document for "Premium-Only" Section 125 Plan ❑
A copy of the Cafeteria Plan Document template along with the Adoption Agreement constitutes your Cafeteria Plan. Please retain these documents as part of your permanent records.

3. Cafeteria Plan – Plan Description ❑
Complete and distribute to all eligible employees no later than the effective date of the Plan.

4. Employee Elections ❑
Each eligible employee must authorize the Employer to withhold the employee cost of the health care coverage pre-tax.

Note: Eligible employees must be given the option to elect out of the Section 125 Cafeteria Plan.

5. Retain – Signed copy of form (Participation Waiver/Election Form and Compensation Reduction Agreement). ❑

6. The Health Connector – Establish an account and provide to the Health Connector a census of participating employees for whom premiums for health care coverage purchased through the Health Connector are to be remitted by the employer (for more information, contact the Connector). ❑

7. Payroll – Notify payroll department/service and advise that contributions for health care coverage are to be deducted pre-tax beginning on the plan's effective date. ❑

8. File – Cafeteria Plan documents from item 2 above with the Health Connector in the time and manner required by the Health Connector in its regulation and any subsequently issued guidance (guidance on timing and process to be issued by the Health Connector at a later date; filing is required by October 1, 2007, but no documents can be accepted before September 1, 2007). ❑

Appendix B2 – Sample New Hire Checklist

ABC Company
Cafeteria Plan

Check When Completed

1. Cafeteria Plan – Plan Description – Distribute a Plan Description to the new employee prior to employee's eligibility to elect the Plan. ❑

2. Election Forms - Each eligible employee must authorize the employer to withhold the employee cost of health care coverage on a pre-tax basis. ❑

Note: Eligible employees must be given the option to elect out of the Section 125 Cafeteria Plan.

3. File - File the signed forms and maintain as part of your permanent records. ❑

4. The Health Connector – Notify the Health Connector that the new employee should be added to your account (for more information, contact the Health Connector). ❑

5. Payroll Service - Contact your payroll service and advise that the new Employee will be participating (pre-tax) in the Section 125 Plan. ❑

Appendix C1 – Sample Employer Adoption Agreement

ADOPTION AGREEMENT
FOR
SECTION 125 CAFETERIA PLAN

FOR REVIEW BY EMPLOYER AND ITS LEGAL COUNSEL

NOT INTENDED FOR USE BY SMALL GROUP EMPLOYERS DESIGNATING A BENCHMARK PLAN

ADOPTION AGREEMENT
SECTION 125 CAFETERIA PLAN

This Adoption Agreement must be completed in conjunction with the accompanying "Premium Only" Section 125 Cafeteria Plan document. These documents should be reviewed by the Employer and its legal counsel prior to execution.

I. Basic Plan Information.

A. The name of the adopting Employer is:

_____

_____

B. The name of the Plan shall be the Section 125 Cafeteria Plan for [name of adopting Employer listed in Section I.A above] (hereinafter referred to as the "Plan").

C. The Effective Date (the initial effective date following adoption) of the Plan is: _____. In the event that the accompanying Plan document is an amended and restated version of the Plan previously adopted by the Employer, the amended and restated Plan document shall be effective as of the date set forth on the cover page of the Plan document.

D. The effective date of the Employer's status as a 151F Employer in accordance with 956 CMR 4.00 is: *(check one)*

❑ July 1, 2007; or

❑ January 1, 20__.

The Plan Year of the Plan is: *(check one)*

❑ the period beginning on the Effective Date and ending on the next following June 30 and each 12-consecutive month period beginning July 1 thereafter;

❑ the period beginning on the Effective Date and ending on the next following December 31 and each 12-consecutive month period beginning January 1 thereafter;

❑ the period beginning on the Effective Date and ending on the next following March 31, and each 12-consecutive month period beginning April 1 thereafter; or

❑ Other:

_____

E. The Employer's Federal "Employer Identification Number" is:

_____

II. Participating Employers. The definition of "Employer" under the Plan includes the Employer and any Participating Employers.

DEFAULT ELECTION: (*check if elected)*

❑ The default election under the Plan is that no organization or other entity that is affiliated with or related to the Employer shall participate in this Plan as a Participating Employer.

In lieu of the default election, the Employer may elect to permit some or all organizations or entities affiliated with or related to the Employer to participate as Participating Employers under this Plan as follows:

OPTIONAL ELECTION: (*check if elected in lieu of default option and please **complete Schedule D** of this Adoption Agreement)*:

❑ The Employer elects to include under this Plan the Participating Employers listed on **Schedule D**, which shall each be considered an Employer under the Plan. The Employer assumes full responsibility for such designation.

III. Participant Eligibility.

DEFAULT ELECTION: (*check if elected)*

❑ The default election under the Plan is that all Employees shall become Eligible Employees upon meeting the eligibility requirements set forth on **Schedule A**. Please **complete Schedule A** of this Adoption Agreement.

In lieu of the default election, the Employer may elect to exclude certain classes of Employees as follows:

OPTIONAL ELECTION: (*check if elected in lieu of default option and please* ***complete Schedule A*** *of this Adoption Agreement*):

❑ Employees shall become Eligible Employees upon meeting the eligibility requirements set forth on **Schedule A** *(please* ***complete Schedule A*** *of this Adoption Agreement)*; provided, however, that the following classes of Employees are excluded from the definition of Eligible Employee (*if elected, check all that apply*):

❑ Employees who are eligible for any other section 125 cafeteria plan of the Employer.

❑ Employees who are less than 18 years of age.

❑ Temporary Employees, as defined in the Plan.

❑ Employees working, on average, less than sixty-four (64) hours per month for an Employer.

❑ Employees who are considered wait staff, service employees or service bartenders (as defined in M.G.L. c. 149, section 152A) and who earn, on average, less than $400 in monthly payroll wages. Tip income is not considered wages for this purpose.

❑ Student Employees who are employed as interns or as cooperative education student workers.

❑ Seasonal Employees, as defined in the Plan, 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.

❑ Employees on whose behalf the Employer is required to contribute to a Multiemployer Health Benefit Plan based on their employment.

❑ Other excluded classes *(if elected, please* ***complete Schedule A*** *of this Adoption Agreement)*.

IV. Employer Contributions.

DEFAULT ELECTION: (*check if elected)*

❑ The default election under the Plan is that the Employer will not make any contributions toward the monthly cost of coverage elected by the Participant under the Plan. Therefore, under this default election, the Participant is responsible for 100% of the monthly cost of coverage elected by the Participant under the Plan.

In lieu of the default election, the Employer may elect to make periodic contributions toward the monthly cost of coverage as follows:

OPTIONAL ELECTION: (*check if elected in lieu of default option and please* ***complete Schedule B*** *of this Adoption Agreement*):

❑ The Employer elects to make periodic contributions toward the monthly cost of coverage elected by Participants under the Plan.

Please **complete Schedule B** of this Adoption Agreement to establish the formula for Employer Contributions (*required if this option is elected*).

V. Medical Care Coverage Options.

DEFAULT ELECTION: (*check if elected)*

❑ The default medical care coverage options available to Participants under the Plan are any and all policies of medical insurance that have been granted the seal of approval by the Commonwealth Health Insurance Connector Authority. Any medical care coverage option that subsequently loses the Connector's seal of approval will continue to be a medical care coverage option under the Plan, but only to the extent that Participants enrolled in such medical care coverage option on the date the seal of approval is lost remain enrolled in that medical care coverage option without interruption.

Such medical care coverage options are available to Participants on a voluntary basis, without endorsement by the Employer and are not intended to be part of the Employer's benefit program.

In lieu of the default election, the Employer may elect the following:

OPTIONAL ELECTION: (*check if elected in lieu of default option and please **complete Schedule C** of this Adoption Agreement*):

❑ The following will be considered medical care coverage options available to Participants under the Plan:

- Any and all policies of medical insurance that have been granted the seal of approval by the Commonwealth Health Insurance Connector Authority. Any medical care coverage option that subsequently loses the Connector's seal of approval will continue to be a medical care coverage option under the Plan, but only to the extent that Participants enrolled in such medical care coverage option on the date the seal of approval is lost remain enrolled in that medical care coverage option without interruption.

- Any other medical insurance identified on **Schedule C** *(please **complete Schedule C** of this Adoption Agreement).*

Such medical care coverage options are available to Participants on a voluntary basis, without endorsement by the Employer and are not intended to be part of the Employer's benefit program.

VI. Employer's Execution of Adoption Agreement

Having made the elections described in this Adoption Agreement, the Employer hereby adopts the Plan (consisting of this Adoption Agreement, including Schedules, and the attached Section 125 Cafeteria Plan document), which Plan is hereby executed in its name and on its behalf by a duly authorized representative of the Employer, or his or her authorized delegate.

FOR THE EMPLOYER

Signature: _____
Name: _____
Title: _____
Date: _____

WITNESS SIGNATURE

Signature: _____
Date: _____

SCHEDULE A – ELIGIBILITY REQUIREMENTS UNDER THE PLAN; OTHER CLASSES OF EMPLOYEES EXCLUDED FROM THE DEFINITION OF ELIGIBLE EMPLOYEE UNDER THE PLAN

Describe eligibility requirements under the Plan below:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

***General Rule**: The eligibility requirements above may include an eligibility waiting period that:*

- *corresponds with (and does not exceed) the eligibility waiting period for enrollment in the applicable medical care coverage option(s) available to the Eligible Employee under the Employer's Section 125 Cafeteria Plan; provided the Employer makes contributions toward such medical care coverage option(s); and/or*

- *does not exceed 2 months (e.g., March 1 to May 1; or March 20 to May 20 is considered two months) if the Employer makes no contribution toward the applicable medical care coverage option(s) available to the Eligible Employee under the Section 125 Cafeteria Plan.*

***Special rule for Employers complying with M.G.L. c. 151F as of July 1, 2007**: the eligibility waiting period, if any, under this Plan for those who are employed on July 1, 2007 may be extended to no later than September 1, 2007.)*
Describe other classes of excluded employees below:

_____
_____
_____

The Employer represents that it has consulted with its own legal counsel, and assumes full responsibility for its exclusion elections.

SCHEDULE B – FORMULA FOR EMPLOYER CONTRIBUTIONS UNDER THE PLAN

Describe the Employer contribution amount per Participant. This amount may be expressed as a percentage of monthly cost or as a flat monthly dollar amount.

_____
_____
_____
_____
_____
_____
_____

If the formula for Employer contributions varies by class of Employees, the Employer assumes full responsibility for its Employer contribution design.

In no event shall the existence of any Employer contributions for monthly premium costs, as indicated above, be construed to require the Employer to pay or otherwise be liable for any deductible, coinsurance, copayment or other cost-sharing amounts related to the applicable medical care coverage option elected by the Participant.

SCHEDULE C – ADDITIONAL MEDICAL CARE COVERAGE OPTIONS UNDER THE PLAN

Describe any additional medical care coverage options available to Participants under the Plan. Include the effective date the coverage is first available as a medical care coverage option under the Plan.

_____
_____
_____
_____
_____
_____
_____

SCHEDULE D – PARTICIPATING EMPLOYERS OF THE EMPLOYER SPONSOR

The following organizations and entities that shall be Participating Employers under the Plan:

Name of Participating Employer	Federal Employer Identification Number

Appendix C2 – Sample Plan Document for Premium-only Plan

PLAN DOCUMENT
FOR
"PREMIUM ONLY"

SECTION 125 CAFETERIA PLAN

[Amended and Restated], Effective July 1, 2007

FOR REVIEW BY EMPLOYER AND ITS LEGAL COUNSEL

Section 125 Cafeteria Plan

Table of Contents

ARTICLE PAGE

Table of Contents, (con't)

ARTICLE PAGE

Section 125 Cafeteria Plan

Article 1. *Introduction.*

1.1. Establishment; Purpose of Plan. The Employer [adopts] [amends, restates and continues] the Plan consisting of this Plan document, the Adoption Agreement, the attached Schedules, and amendments thereto. The name of the Plan shall be the name stated in Section I.A. of the Adoption Agreement. The purpose of this Plan is to provide Participants with a choice between regular cash compensation and Optional Benefit Coverages.

1.2. Cafeteria plan status. This Plan is intended to qualify as a "cafeteria plan" under Section 125 of the Internal Revenue Code of 1986, as amended, and is to be interpreted in a manner consistent with the requirements of Section 125. To the extent required, this Plan is also intended to be maintained as required by, and in accordance with, M.G.L. c. 151F, 956 CMR 4.00 and such other rules and regulations of the Commonwealth Health Insurance Connector Authority, as amended from time to time.

Article 2. *Definitions.*

Wherever used in this Plan, the singular includes the plural and the following terms have the following meanings, unless a different meaning is clearly required by the context:

2.1. "Administrator" means the Employer or such other person or committee as may be appointed from time to time by the Employer to supervise the administration of the Plan.

2.2. "Code" means the Internal Revenue Code of 1986, as amended from time to time. Reference to any section or subsection of the Code includes reference to any regulations thereunder and any comparable or succeeding provisions of any legislation which amends, supplements or replaces such section or subsection.

2.3. "Coverage Period" means the Plan Year.

2.4. "Effective Date" means the date set forth in Section I.C. of the Adoption Agreement.

2.5. "Eligible Employee" means an Employee who meets the eligibility requirements described in Section III of the Adoption Agreement. An individual who does not meet the eligibility requirements in the Adoption Agreement shall not be eligible to participate in the Plan under any circumstances.

2.6. "Employee" means any individual who is employed by the Employer at a Massachusetts location, whether or not the individual is a Massachusetts resident. Employee includes, by way of example and not by way of limitation, full-time Employees, part-time Employees, Temporary Employees, and Seasonal Employees. Employee shall not include an Independent Contractor or an individual who is self –employed in accordance with Code section 401(c).

2.7. "Employer" means the entity identified in Section I.A of the Adoption Agreement and any successor to all or a major portion of its assets or business, by merger or otherwise, that assumes the obligations of the Employer under the Plan.

2.8. "Independent Contractor" means an individual that provides services not deemed to be employment under M.G.L. c. 151A, § 2.

2.9. "Key Employee" means any person who is a key employee, as defined in section 416(i)(1) of the Code, with respect to the Employer.

2.10. "Multiemployer Health Benefit Plan" means a health benefit plan to which more than one employer is required to contribute, which is maintained pursuant to one or more collective bargaining agreements between one or more employee organizations and more than one employer, and there is evidence that such employer contributions to the Multiemployer Health Benefit Plan were the subject of good faith bargaining between such employee representatives and such employers.

2.11. "Optional Benefit Coverages" means the medical care coverage option(s) ("MCCO") available to a Participant as set forth in Section V of the Adoption Agreement.

2.12. "Participant" means any individual who participates in the Plan in accordance with Article 3.

2.13. "Participating Employer" means any subsidiary or affiliated organization or entity and any successor(s) of any of them which, with the approval of the Employer, and subject to such conditions as the Employer may impose, adopts the Plan.

2.14. "Plan" means the cafeteria plan set forth in this Plan document and the Adoption Agreement, the name of which is designated in the Adoption Agreement, together with any and all Schedules and amendments thereto. The terms of this Plan document shall be interpreted in accordance with the elections made by the Employer in the Adoption Agreement.

2.15. "Plan Year" means the period set forth in Section I.E of the Adoption Agreement.

2.16. "Seasonal Employee" means an Employee who is a seasonal employee that works for an Employer that is a seasonal employer, as such terms are defined in M.G.L. c. 151A, section 1.

2.17. "Temporary Employee" means an individual that works for an Employer on either a full or part time basis; whose employment is explicitly temporary in nature and does not exceed 12 consecutive weeks during the period from October 1 through September 30.

Article 3. *Participation.*

3.1. Commencement of participation. Each Eligible Employee will become a Participant in this Plan on the date he or she becomes an Eligible Employee, subject to his or her completion of any applicable waiting period set forth on the attached Adoption Agreement. Participation in this Plan means only that the Participant is entitled to contribute toward his or her share of the cost of Optional Benefit Coverages on a pre-tax basis. The date participation in this Plan commences does not necessarily correspond with the effective date of any Optional Benefit Coverage elected by the Participant. Each Participant may elect Optional Benefit Coverages in accordance with, and subject to, the procedures set forth in Article 4 and such other procedures as may be established by the Administrator from time to time.

3.2. Cessation of participation. A Participant shall cease to be a Participant as of the earlier of (a) the date on which the Plan terminates or (b) the date on which he or she ceases to be an Eligible Employee.

3.3. Reinstatement of former Participant. A former Participant who meets the requirements for an Eligible Employee will become a Participant again if and when he or she becomes an Eligible Employee, subject to the completion of any applicable waiting period.

Article 4. *Optional Benefit Coverages.*

4.1. Coverage options. Each Participant may choose under this Plan to receive his or her full compensation in cash or to have all or a portion of such compensation applied by the Employer toward the cost of the Optional Benefit Coverages elected by the Participant. Notwithstanding anything herein to the contrary, Optional Benefit Coverages shall be limited to those medical care coverage options (MCCO) identified in Section V of the Adoption Agreement to the extent they are available to the Participant.

4.2. Description of Optional Benefit Coverages. While the election of Optional Benefit Coverages may be made under this Plan, the coverages and benefits elected by Participants will be provided not by this Plan but by the applicable MCCO identified in the Adoption Agreement. The types and amounts of benefits available under each MCCO, the requirements for participating in such MCCO, the effective date of the MCCO coverage and the other terms and conditions of coverage and benefits under such MCCO are as set forth from time to time in the insurance policy forms that constitute (or are incorporated by reference in) the applicable MCCO. The benefit descriptions in such MCCO and in the evidence of coverage corresponding to such MCCO, as in effect from time to time, are hereby incorporated by reference into this Plan.

4.3. Election of Optional Benefit Coverages in Lieu of Cash. A Participant may elect under this Plan, in accordance with the procedures described in Sections 4.4, 4.5 and 4.6, to receive one or more Optional Benefit Coverages to the extent available to the Participant under the Adoption Agreement. If a Participant elects an Optional Benefit Coverage for a Coverage Period, and if the Participant is

required to pay all or a share of the cost of such coverage in accordance with Section IV of the Adoption Agreement, such share shall be paid by a reduction in the Participant's regular compensation for the Coverage Period. The balance of the cost of each such coverage, if any, shall be p aid by the Employer under this Plan with nonelective Employer contributions. In the event that the Participant's regular compensation is insufficient in amount to pay the Participant's share of the monthly cost of such Optional Benefit Coverage by compensation reduction, the Employer has no responsibility under this Plan to cover, pay or advance on behalf of the Participant any such shortfall and the Participant shall make immediate arrangements to pay any such shortfall on an after-tax basis in accordance with the procedures specified by the Administrator.

4.4. Election procedure. Prior to the commencement of each Coverage Period, the Administrator shall provide (or make available) a means of election for each Participant and for each other individual who is expected to become a Participant at the beginning of the applicable Coverage Period. The election shall be effective as of the first day of the Coverage Period. Each Participant who desires to elect an Optional Benefit Coverage available for the Coverage Period shall so specify in his or her election. The Participant shall agree to a reduction in his or her compensation equal to the cost of the Optional Benefit Coverages elected by the Participant. Each election must be made on or before such date as the Administrator shall specify.

4.5. New Participants. Before, or as soon as practicable after, an individual becomes a Participant under Section 3.1 or 3.3, the Administrator shall provide the means of election described in Section 4.4 to the individual. If the individual desires one or more Optional Benefit Coverages for the balance of the Coverage Period, the individual shall so specify in his or her election. The Participant shall agree to a reduction in his or her compensation equal to the cost of the Optional Benefit Coverages elected by the Participant. Each election must be made on or before such date as the Administrator shall specify.

4.6. Failure to make election.

(a) A new Participant's failure to make an election under Section 4.4 or 4.5 on or before the due date specified by the Administrator for the Coverage Period in which he or she becomes a Participant shall constitute an election by the Participant to receive his or her full compensation in cash.

(b) An existing Participant's failure to make an election relating to an Optional Benefit Coverage on or before the due date specified by the Administrator for any subsequent Coverage Period shall constitute (1) a re-election of the same coverage, if any, as was in effect just prior to the end of the preceding Coverage Period (to the extent such Optional Benefit Coverage remains available under the Plan), and (2) an agreement to a reduction in the Participant's compensation for the subsequent Coverage Period equal to the cost of such coverage.

4.7. Revocation or change of election by the Participant during the Coverage Period.

(a) Any election made under the Plan (including an election made through inaction under Section 4.6) shall be irrevocable by the Participant during the Coverage Period except as otherwise provided in (b) through (k) below.

(b) With respect to an Optional Benefit Coverage, a Participant may revoke an election for the balance of the Coverage Period and, if desired, file a new election in writing if, under the facts and circumstances, (1) a change in status occurs, and (2) the requested revocation and new election satisfy the consistency requirements in Section 4.8 below. For this purpose, a change in status includes the following events:

(1) Legal marital status. An event that changes a Participant's legal marital status, including marriage, death of spouse, divorce, or legal separation or annulment.

(2) Number of dependents. An event that changes a Participant's number of dependents (as defined in Code Section 152), including birth, death, adoption or placement for adoption.

(3) Employment Status. An event that changes the employment status of the Participant, the Participant's spouse or dependent, including termination or commencement of employment, a strike or lockout, a commencement or return from an unpaid leave of absence, or a change in worksite, as well as any other change in the individual's employment status that results in the individual becoming (or ceasing to be) eligible under a benefit plan of the Employer.

(4) Requirements For Unmarried Dependents. An event that causes a dependent to satisfy or cease to satisfy the requirements for coverage on account of attainment of age, student status, or any similar circumstance.

(5) Residence. A change in the place of residence of the Participant or his or her spouse or dependent.

(6) Other. Such other events that the Administrator determines will permit the revocation of an election (and, if applicable, the filing of a new election) during a Coverage Period under regulations and rulings of the Internal Revenue Service.

(c) In the case of coverage under a medical plan identified in the Adoption Agreement, a Participant may revoke an election for the balance of the Coverage Period and file a new election that corresponds with the special enrollment rights provided in Code Section 9801(f) pertaining to HIPAA special enrollment rights, whether or not the change in election is permitted under Section 4.7(b) above.

(d) In the case of a judgment, decree or order resulting from a divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order) that requires health coverage for a Participant's child or for a foster child who is a dependent of the Participant, a Participant may change his or her election (1) in order to provide coverage for the child under a health coverage identified in the Adoption Agreement if the order so requires, or (2) in order to cancel a health coverage identified in the Adoption Agreement for the Participant's child if such order requires the Participant's spouse or former

spouse or another individual to provide coverage for the child and that coverage is, in fact, provided.

(e) In the case of a medical Optional Benefit Coverage, a Participant may revoke an election in writing for the balance of the Coverage Period and file a new election in writing in order to cancel or reduce such medical Optional Benefit Coverage for the Participant and/or for one or more covered dependents of the Participant to the extent that such individual becomes entitled to coverage under Part A or Part B of Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928 of the Social Security Act (the program for distribution of pediatric vaccines). In addition, if the Participant or any eligible dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, the Participant may file a new election in writing for the balance of the Coverage Period to commence or increase a medical Optional Benefit Coverage.

(f) In the case of a medical Optional Benefit Coverage, if the Participant's share of the cost of such coverage significantly increases or significantly decreases during the Coverage Period, the Participant may make a corresponding change in election under the Plan for the balance of the Coverage Period, as follows:

(1) for a significant cost increase, Participants electing such coverage for the Coverage Period may revoke their election and either elect a similar Optional Benefit Coverage for the balance of the Coverage Period, or drop such coverage if there is no similar Optional Benefit Coverage; or

(2) for a significant cost decrease, Participants may elect to commence participation in the Optional Benefit Coverage with the significant cost decrease and may make corresponding election changes regarding similar coverage, for the balance of the Coverage Period.

(g) In the case of a medical Optional Benefit Coverage, if the Participant or his or her spouse or dependent experiences a significant curtailment in coverage during the Coverage Period, the Participant may make a corresponding change in election under the Plan for the balance of the Coverage Period as follows:

(1) for a significant curtailment that is not a loss of coverage, the Participant electing such coverage for the Coverage Period may revoke his or her election and elect a similar medical Optional Benefit Coverage for the balance of the Coverage Period; or

(2) for a significant curtailment that is (or is deemed by the Administrator to be) a loss of coverage, the Participant electing such coverage for the Coverage Period may revoke his or her election and either elect a similar Optional Benefit Coverage for the balance of the Coverage Period, or drop such coverage if there is no similar Optional Benefit Coverage.

(h) If during the Coverage Period a new Optional Benefit Coverage becomes available, or an existing Optional Benefit Coverage is significantly improved, Participants may elect the new or significantly improved coverage, and may make corresponding election changes regarding similar coverage, for the balance of the Coverage Period.

(i) In the event that a Participant's spouse or dependent makes an election change under a plan maintained by his or her employer, the Administrator may permit the Participant to revoke an election under this Plan and make a new election for the balance of the Coverage Period that is on account of and corresponds with the election change made by the Participant's spouse or dependent, if:

(1) the election change made by the Participant's spouse or dependent under his or her employer's plan satisfies the regulations and rulings under Code section 125; or

(2) the period of coverage under the plan maintained by the employer of the Participant's spouse or dependent does not correspond with the Coverage Period of this Plan.

(j) In the event that a Participant, his or her spouse or dependent loses group health coverage sponsored by a governmental or educational institution, the Participant may elect a medical Optional Benefit Coverage for the balance of the Coverage Period for the Participant, his or her spouse or dependent.

(k) Any application for a revocation and new election under this Section 4.7 must be made within the time specified by the Administrator following the date of the actual event and shall be effective at such time as the Administrator shall prescribe, unless otherwise required by law.

4.8. Consistency Rules. A Participant's requested revocation and new election will be consistent with a change in status if the election change is on account of and corresponds with a change in status that affects the eligibility for coverage under a plan of the Employer or under a plan maintained by the employer of the Participant's spouse or dependent. A change in status that affects eligibility under the Employer's plan shall include a change in status that results in the increase or decrease in the number of a Participant's family members or dependents who may benefit from coverage under the plan.

4.9. Changes by Administrator. If the Administrator determines, before or during any Coverage Period, that the Plan may fail to satisfy for such year any nondiscrimination or other requirement imposed by the Code or any limitation on benefits provided to Key Employees, the Administrator shall take such action as the Administrator deems appropriate, under rules uniformly applicable to similarly situated participants, to assure compliance with such requirement or limitation. Such action may include, without limitation, a modification of elections by highly compensated Employees (as defined by the Code for purposes of the nondiscrimination requirement in question) or Key Employees without the consent of such Employees.

4.10. Adjustment of Compensation Reductions. If the cost of an Optional Benefit Coverage provided to a Participant increases or decreases during a Coverage Period, including any increase or decrease due to a change in the Participant's salary, a corresponding change shall be made in the compensation reductions of the Participant in an amount reflecting such increase or decrease, as determined by the Administrator.

4.11. Automatic termination of election. Any election made under this Plan (including an election made through inaction under Section 4.6) shall automatically terminate on the date on which the Participant ceases to be a Participant in the Plan, although coverage or benefits may continue if and to the extent provided by such coverage. In the event such a former Participant again becomes a Participant within 30 days of ceasing to be a Participant, the elections previously in effect for the Participant shall be automatically reinstated for the balance of the Coverage Period, except as otherwise elected by the Participant in accordance with Section 4.7.

4.12. Maximum elective contributions. The maximum amount of elective contributions under the Plan for any Participant shall be the total cost to the Participant for the Coverage Period of the most expensive Optional Benefit Coverages that any Participant could elect.

4.13. Cessation of required contributions. Nothing in this Plan shall prevent the cessation of coverage or benefits under any Optional Benefit Coverage, in accordance with the terms of such coverage, on account of a Participant's failure to pay the Participant's share of the cost of such coverage or benefits, through compensation reduction or otherwise.

4.14. Elections Via Other Media. The Administrator may, in its discretion, use any telephonic, electronic or other alternative media form that it deems necessary or appropriate for the election of Optional Benefit Coverages under the Plan.

4.15. Coordination with FMLA. Notwithstanding any other provision of this Plan, the Administrator may (a) permit a Participant to revoke (and subsequently reinstate) his or her election of one or more Optional Benefit Coverages under the Plan, and (b) adjust a Participant's compensation reduction as a result of a revocation or reinstatement to the extent the Administrator deems

necessary or appropriate to assure the Plan's compliance with the provisions of the Family and Medical Leave Act of 1993 and any regulations pertaining thereto.

4.16. Special Rule for Certain Covered Individuals. Notwithstanding anything in this Plan to the contrary, the cost of providing Optional Benefit Coverage to an individual as a dependent of the Participant (where the covered individual is not a dependent of the Participant for purposes of Code section 152, as modified by Code section 105(b) and IRS Notice 2004-79) shall be paid by the Participant with after-tax contributions. Such costs shall either be deducted by the Employer from the after-tax compensation of the Participant or, to the extent the cost of such Optional Benefit Coverage is paid from compensation reduction or any other form of Employer contribution, shall be treated as taxable compensation received by the Participant and contributed by the Participant on an after-tax basis.

Article 5. *Administration of Plan.*

5.1. Plan Administrator. The administration of the Plan shall be under the supervision of the Administrator. It shall be a principal duty of the Administrator to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan without discrimination among them. The Administrator will have full discretionary power to administer the Plan in all of its details, subject to applicable requirements of law. For this purpose, the Administrator's discretionary powers will include, but will not be limited to, the following discretionary authority, in addition to all other powers provided by this Plan:

(a) To make and enforce such rules and regulations as it deems necessary or proper for the efficient administration of the Plan;

(b) To interpret the Plan;

(c) To decide all questions concerning the Plan and the eligibility of any person to participate in the Plan;

(d) To appoint such agents, counsel, accountants, consultants and other persons as may be required to assist in administering the Plan; and

(e) To delegate its responsibilities under the Plan and to designate other persons to carry out any of its responsibilities under the Plan, any such delegation or designation to be in writing.

Any determination by the Administrator, or its authorized delegate, shall be final and conclusive on all persons, in the absence of clear and convincing evidence that the Administrator or delegate acted arbitrarily and capriciously. Notwithstanding the foregoing, any claim which arises under any Optional Benefit Coverage shall not be subject to review under this Plan, and the Administrator's authority under this Section 5.1 shall not extend to any matter as to which another administrator or entity is empowered to make determinations under such Optional Benefit Coverage.

5.2. Examination of records. The Administrator will make available to each Participant such of its records under the Plan as pertain to the Participant, for examination at reasonable times during normal business hours; provided, however, that the Administrator shall have no obligation to disclose any records or information which the Administrator, in its sole discretion, determines to be of a privileged or confidential nature.

5.3. Reliance on tables, etc. In administering the Plan, the Administrator will be entitled to the extent permitted by law to rely conclusively on all tables, valuations, certificates, opinions and reports which are furnished by, or in accordance with the instructions of, the administrators of the plans identified in the Adoption Agreement, or by accountants, counsel or other experts employed or engaged by the Administrator.

5.4. Nondiscriminatory exercise of authority. Whenever, in the administration of the Plan, any discretionary action by the Administrator is required, the Administrator shall exercise its authority in a nondiscriminatory manner so that all persons similarly situated will receive substantially the same treatment.

Article 6. *Amendment and Termination of Plan.*

6.1. Amendment of Plan. The power to amend the Plan, in whole or in part, shall be vested in the Employer, which shall have the sole discretion to make all amendments to the Plan or any of its provisions. Such amendment shall be effected by a written instrument signed by a duly authorized representative of the Employer, or his or her authorized delegate, and delivered to the Administrator.

Subject to the foregoing provisions, the Schedules in the Adoption Agreement may be amended without the need to execute a new Adoption Agreement. Such amendment shall be made by the Employer in a written certification specifying that the Plan is amended by substituting the amended Schedule.

6.2. Termination of Plan. The Employer has established the Plan with the bona fide intention and expectation that it will be continued indefinitely, but the Employer will have no obligation whatsoever to maintain the Plan for any given length of time and may discontinue or terminate the Plan at any time, without liability, by a written instrument signed by a duly authorized representative of the Employer, or his or her authorized delegate, and delivered to the Administrator.

Article 7. *Miscellaneous Provisions.*

7.1. Information to be furnished. Participants shall provide the Employer and the Administrator with such information and evidence, and shall sign such documents, as may reasonably be requested from time to time for the purpose of administration of the Plan.

7.2. Limitation of rights. Neither the establishment of the Plan nor any amendment thereof, nor the payment of any benefits, will be construed as giving to any Participant or other person any legal or equitable right against the Employer or the Administrator, except as provided herein.

7.3. Employment Not Guaranteed. Nothing contained in the Plan nor any action taken hereunder shall be construed as a contract of employment or as giving any Employee any right to be retained in the employ of the Employer.

7.4. Governing law. Except to the extent federal law applies, this Plan shall be construed, administered and enforced according to the laws of the Commonwealth of Massachusetts.

Appendix C3 – Sample Plan Description for Premium-only Plan

Plan Description for Premium-only Plan

[Amended and Restated/Effective] _____

[THIS PLAN DESCRIPTION IS INTENDED FOR USE BY EMPLOYERS ALLOWING EMPLOYEES TO ACCESS COMMONWEALTH CHOICE COVERAGE THROUGH A SECTION 125 CAFETERIA PLAN ON A VOLUNTARY BASIS. IT IS NOT INTENDED FOR USE BY SMALL GROUP EMPLOYERS DESIGNATING A BENCHMARK PLAN AND MAKING AN EMPLOYER CONTRIBUTION.]

This plan description provides an overview of the requirements for participation in the Section 125 Cafeteria Plan and is intended to be a brief summary. The Plan is governed by a formal plan document. If there are any differences between this summary and the official plan document, the plan document will govern.

Introduction

We are pleased to announce that we have [established/amended and restated] our Section 125 Cafeteria Plan (the "Plan") under which you may pay your medical care coverage premiums on a pre-tax basis. Under the Massachusetts Health Care Reform Law, you are now eligible for favorable tax treatment of your voluntary medical care coverage premiums even though you are not eligible for group medical care coverage through your Employer. Your participation in medical care coverage is completely voluntary.

Participation In The Plan

Under the Plan, you may choose to receive your entire compensation in cash or use a portion of it to pay for certain voluntary medical care coverage premiums (See "Medical Care Coverage" below). When you elect to pay for your medical care coverage premiums, your regular compensation will be reduced on a pre-tax basis by the amount of your premium payment for the coverage you have selected. This means that you will pay less in taxes each year.

Important note: If you decide to pay for medical care coverage using pre-tax income, the amount withheld from your pay will not be subject to Social Security ("FICA") taxes. This could result in a reduction in the Social Security benefits you receive at retirement if you earn less than the "taxable wage base." The taxable wage base for 2007 is $97,500 and is adjusted annually. The tax advantages you gain by paying your medical care coverage premiums with pre-tax income may, however, offset any possible reduction in Social Security benefits and you should consult a tax advisor to determine whether in your situation the benefits achieved outweigh any potential reduction of Social Security benefits.

Medical Care Coverage

You can use pre-tax dollars to purchase any medical care coverage that has been granted the seal of approval by the Commonwealth Health Insurance Connector Authority (the "Connector"). [1] This voluntary coverage is not provided by this Plan or sponsored by your Employer, is not endorsed by your Employer and is not part of your Employer's regular benefit program. Your eligibility for the medical care coverage is determined by the Health Connector and the applicable insurance carrier.

Additionally, although the Health Connector has granted its seal of approval to these medical care coverage options, coverage is provided by the insurance carrier issuing the applicable medical insurance policy. Neither the Health Connector nor your Employer have any liability for any benefits due, or alleged to be due, under any such medical insurance policies.

[1] [*This section will need to be tailored if additional medical care coverage options are made available.*]

Eligibility

You are eligible to participate in this Plan if (i) you are an employee of [insert name of company], (the "Employer"); (ii) you are not an "excluded employee;" and (iii) you have completed [__] months of service.[2]

You are an "excluded employee" if you are:

(i) eligible for another Section 125 Cafeteria Plan offered by your Employer;

(ii) less than 18 years of age;

(iii) an employee on whose behalf the Employer is required to contribute to a Multiple Employer Health Benefit Plan based on your employment;

(iv) a temporary employee;

(v) a part-time employee working, on average, fewer than 64 hours per month;

(vi) wait staff, service employee or service bartender and you earn less than $400 in monthly payroll wages (which does not include tip income);

(vii) a student employee employed as an intern or a cooperative education student worker;

(vii) a seasonal employee who is an international worker with either a U.S. J-1 student visa, or a U.S. H2B visa and you have travel health insurance; or

Electing To Participate In The Plan

If you are eligible to participate in the Plan and you wish to use pre-tax dollars to pay for voluntary medical care coverage offered through the Health Connector, you must elect coverage within [30 days] following the date you become eligible by selecting a medical care coverage plan and enrolling in that plan. This must be done through the Health Connector. More than one method of enrollment may be available, such as a written enrollment form, electronic enrollment on an internet web site or via telephone. For more information on medical care coverage options offered through the Health Connector and/or to enroll in medical care coverage, please visit the Health Connector's website at www.MAhealthconnector.org.

Your participation in the Plan will be effective [ ] and will remain in effect until you cancel participation as permitted by the Plan or you otherwise become ineligible to participate in the Plan in accordance with its terms.

If you are eligible to participate in the Plan but you either decide not to use pre-tax dollars to pay for medical care coverage, or you do not enroll in medical care coverage within [30 days] following the date you become eligible, you will be deemed to be a participant in the Plan who has elected to waive use of the Plan for the balance of the year. This means that, absent a change in status event (described

[2] [*This needs to be customized by the employer based on the employer's eligibility requirements.*]

in the next section below), you will not be able to elect to use pre-tax dollars to purchase medical care coverage until the Plan's next annual enrollment period.

Before the start of each Plan Year (e.g. July 1 - June 30), you will be offered an annual enrollment period to make a new election. If you do not make a new election, your existing election will remain in effect.

Changing Your Election

Generally, you cannot change the medical care coverage elections you have made under the Plan for the balance of the Plan Year. However, you are permitted to change your election if you experience an IRS defined "change in status" and/or other special events as described in the Plan document and summarized below.

Examples of status changes include these events:

- marriage;
- divorce, legal separation or annulment;
- death of your spouse or dependent child;
- birth, adoption or placement for adoption of a child;
- termination of the employment of your spouse or dependent child;
- commencement of the employment of your spouse or dependent child;
- your or your spouse's or dependent child's commencement or return from an unpaid leave of absence from employment;
- adjustment to your or your spouse's or dependent child's work schedule, such as a switch between part-time and full-time work, a strike, a lockout or an increase or reduction in hours of employment, that causes a loss of coverage;
- a change in your or your spouse's or dependent child's worksite or residence that causes a loss of current coverage eligibility;
- adjustments in dependent status through satisfying or ceasing to satisfy the age, student status or other requirements to qualify as a dependent under the Plan;
- significant change in your or your spouse's health coverage attributable to the spouse's employment; and
- leave of absence under the Family Medical and Leave Act.

Your election may also be changed if one of these special events occurs:

- the issuance of a judgment, decree or order that requires accident or health coverage for your dependent child.
- your or your spouse's or dependent child's entitlement to Medicare or Medicaid that causes a loss of coverage.
- a "significant" increase in the cost of any benefit under the Plan.

- elimination or "significant" cutback in coverage provided by an insurance company or other third party. You may cancel your election and receive coverage under a similar plan, provided both plans agree to make the change.
- your failure to make the required premium payment. Your participation in the Plan will be canceled and you will not be able to make a new election for the rest of the Plan Year.
- your separation from service. If you separate from service (including death), your participation in the Plan will be cancelled.

If you have a status change and/or other special event and you want to cancel or modify your election for the remainder of a Plan Year, you must file a request with your Employer within 30 days of the event. Keep in mind that any change to your election must be consistent with your status change. Your Employer will consider your application and inform you of its decision.

All change requests received more than 30 days after the date the event occurred will not be processed. To make the change after this 30 day period, you will have to wait until the next annual enrollment period or a subsequent status change event, whichever occurs sooner.

Individuals Not Eligible For Pre-Tax Treatment Under This Plan

There are certain instances where an individual is a dependent for medical care coverage purposes but may not be your dependent for purposes of this Plan. For example, if you cannot claim the individual as a dependent on your federal income tax return, but the individual is eligible for coverage under your medical care coverage, the value of the medical coverage for this individual must be paid on an after-tax basis. In addition, domestic partners and same sex spouses are not eligible for the favorable pre-tax treatment unless you can claim them as dependents on your federal income tax return.

Participation While On Leave

If you take a leave of absence for your own serious health condition or to care for family members with a serious health condition or to care for a newborn or adopted child, you may be able to revoke your election. If you revoke your election, you may also reinstate your election when you return to work. See your Employer for more information about your rights.

Termination Of Employment

If you stop working for your Employer, you will no longer be eligible to participate in this Plan and your election to participate will automatically terminate. This means that your medical care coverage premiums payable after you stop working for your Employer must be paid directly to the Health Connector on an after-tax basis (unless you subsequently become employed and enroll in another employer's cafeteria plan). In the event you become a participant in this Plan again within 30 days of the date you stopped being a participant and before the end of the same Plan Year, the elections you previously had in effect will automatically be reinstated for the balance of the Plan Year.

Keep in mind, your termination of employment does not affect your underlying medical care coverage. You can keep your medical care coverage in effect by simply continuing to make the required monthly premium contributions by sending after-tax payment directly to the Health Connector by the applicable due date.

Questions

If you have any questions or would like additional information, you can contact [the Employer] at [_____].

Appendix C4 – Sample Board of Directors Consent Form

[COMPANY NAME]

_____

(the "Company")

ACTION BY UNAMINOUS CONSENT IN LIEU OF MEETING OF DIRECTORS

Dated: _____

The undersigned, being all of the Directors of the Company, a Massachusetts Corporation, do hereby consent in writing to the actions set forth in the form of votes immediately following, which shall be treated as votes for all purposes, as fully as if said actions and votes had been adopted at a duly called and held meeting of the Board of Directors of the Company (the "Board").

VOTED: That the Board hereby approves and ratifies the adoption of the Premium Only Section 125 Cafeteria Plan (the "Plan"), effective [_____], in the form attached hereto as Exhibit A, the execution and delivery thereof to be conclusive evidence that the same were authorized by this vote;

VOTED: That the officers of the Company be, and each of them acting singly hereby is, authorized, empowered and directed, in the name and on behalf of the Company, to take any and all actions and to execute or cause to be executed such documents, agreements or other instruments as shall be necessary, convenient or desirable to carry out the intent and purposes of the foregoing votes; and

VOTED: That the officers of the Company be, and each of them acting singly hereby is, authorized to take any and all actions necessary, including but not limited to adopting amendments to the Plan, to comply with Section 125 of the Internal Revenue Code of 1986 and M.G.L. c. 151F and 956 CMR 4.00.

This written consent may be executed in any number of counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument.

DIRECTORS:

_____ _____

_____ _____

Appendix C5 – Sample Employee Waiver /Election Form/ Compensation Reduction Agreement

(ENTER COMPANY NAME) SECTION 125 CAFETERIA PLAN

This form must be completed when an employee elects to either a) waive all pre-tax benefits or b) enroll in a pre-tax benefit deducted from their compensation for their medical care coverage premium amount.

_____

Employer Name (Legal Entity Name)

_____

Employee Name (First, Middle Initial, Last)

_____

Employee Address

_____

Employee Social Security Number Employee Number/ID

Plan Year _____ through _____

❑ **Waiver of Pre-Tax Benefits**

I elect to waive all pre-tax benefits under the Section 125 Cafeteria Plan:

I understand that if I have enrolled for medical care coverage on a separate benefit enrollment form, I will pay the required contribution with after-tax payroll deductions. I understand that I cannot elect pre-tax benefits except and until as described below and any after-tax medical care coverage is outside the Plan.

Prior to each Plan Year I will be offered the opportunity to make a new benefit election for the coming Plan Year. If I do not complete and return a new enrollment form at that time, I will be treated as having elected to continue this election to waive participation as indicated above.

❑ **Election of Pre-Tax Benefits**

I understand that an amount equal to the annual contributions for the coverage I have elected, divided by the number of pay periods in the Plan Year, will be deducted on a pre-tax basis from

each of my paychecks (unless another method is prescribed by the Plan Administrator) to pay for the coverage that I elect.

❑ **Election for Medical Care Coverage**

On a separate enrollment form(s), I have enrolled in medical care coverage and I have received a schedule showing my share of the contributions for such coverage.

In accordance with my rights under the Plan, I authorize salary reductions in the amount of current premiums being charged for the medical care coverage I have elected as follows:

Medical Care Coverage _____
(Enter Connector Seal of Approval Plan Name from Enrollment Form)

Premium per Month $ _____

I understand that:

- If my required contributions to pay premiums for the elected benefits are increased or decreased while this agreement remains in effect, my compensation reductions will automatically be adjusted to reflect that increase or decrease.
- The Plan Administrator may reduce or cancel my compensation reduction or otherwise modify this agreement in the event he/she believes it advisable in order to satisfy certain provisions of the Internal Revenue Code.
- The reduction in my cash compensation under this agreement shall be in addition to any reductions under other agreements or benefits programs maintained by my employer.
- Pre-tax contributions are not subject to federal income or Social Security ("FICA") taxes. This could result in a reduction in the Social Security benefits I receive at retirement if I earn less than the annual FICA "taxable wage base" ($97,500 for 2007).
- Prior to the first day of each Plan Year I will be offered the opportunity to make a new benefit election for the coming Plan Year. If I do not complete and return a new enrollment form at that time, I will be treated as having elected to continue this benefit election for the new Plan Year. In addition, this compensation reduction agreement will continue by its terms in the amount of the required contribution for the benefit option for the new Plan Year.
- This Agreement is subject to the terms of the employer's Section 125 cafeteria plan, as amended for time to time in effect, shall be governed by and construed in accordance with applicable laws, shall take effect as a sealed instrument under applicable laws, and revokes any prior election and compensation reduction agreement relating to such plan.

_____ _____
Employee Signature Date

Accepted and agreed to by the Employer's Authorized Representative:

By _____ Date _____

Appendix C6 – Sample Employee Revocation/Change in Status Certification

(ENTER COMPANY NAME) SECTION 125 CAFETERIA PLAN

_____

Employer Name (Legal Entity Name)

_____

Employee Name (First, Middle Initial, Last)

_____

Employee Address

_____

Employee Social Security Number Employee Number/ID

Plan Year _____ through _____

As a participant in the Cafeteria (Plan), I am entitled to revoke my current benefit election and enter into a new election in the event I incur certain changes in status permitted by the terms of the Plan.

I hereby revoke my election effective: _____.

I understand that any change in my benefit election must be necessitated by and consistent with the change in status as defined in the Plan and certified by me below:

I certify that I have incurred the following change in status:

- ☐ Marriage
- ☐ Birth of Child, Adoption of Child
- ☐ Divorce, Legal Separation or Annulment
- ☐ Dependent Attending School
- ☐ Moved out of service area for myself, my spouse or dependent
- ☐ Death of my spouse and/or dependent

❑ Switching from part-time to full-time (or vice-versa) employment on the part of me or my spouse, or dependent or reduction or increase in hours, strike or lockout

❑ Termination or commencement of employment by my spouse or dependent

❑ Other permissible event: _____

Date that the change in status occurred (MM/DD/YYYY): _____

The Administrator may require you to provide evidence to document the event which requires the change of election.

_____ _____

Employee Signature Date

_____ _____

Employer Administrator Date

List of Useful Websites

Associated Industries of Massachusetts – provides assistance and educational programs on health care reform – www.aimnet.org

The Connector – for information on individual mandate, minimum creditable coverage, Commonwealth Choice and Commonwealth Care – www.mahealthconnector.org

The Division of Health Care Finance and Policy (DHCFP) – writes regulations for fair share contribution and health insurance responsibility disclosure – www.mass.gov/DHCFP

The Division of Unemployment Assistance – administers the fair share compliance filing process – www.mass.gov/DUA

The Department of Revenue – enforces the individual mandate – www.mass.gov/DOR

The Division of Insurance – defines and enforces the requirements that apply to insured plans purchased from a Massachusetts carrier – www.mass.gov/DOI