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Client Update

August 2006

Massachusetts Health Care Reform:
"An Act Providing Access to Affordable, Quality, Accountable Health Care"
Focused on Chapter 58

Introduction

Governor Mitt Romney recently signed into law a landmark health care reform bill: "An Act Providing Access to Affordable, Quality, Accountable Health Care" (the Act). The bill itself is merely a broad outline for the goal of getting 95% of the Commonwealth's population insured. The details were left to be worked out later. Draft regulations were just released. We have awaited guidance before sending you an alert.

On July 26, 2006, federal officials approved the new health insurance program, allowing the Commonwealth to continue receiving $385 million annually that will provide premium assistance for the working poor to insure themselves. The Division of Health Care Finance and Policy (DHCFP) released Proposed Regulations on June 30, 2006 that offer some clarification of the new statute. Until the details are finalized over the next several months, it is difficult to know exactly the full implications for employers. It is important at this point to be aware of who the Act covers, what major aspects of the Act are, when they become effective, and how the Act will impact employers. Importantly, employers with 10 employees or less are completely exempt from the Act's requirements.

Important Background Information: The Connector

The goals of the Act are to expand health insurance coverage, increase choice for employers and individuals, stimulate competition among providers, and reduce the current burden on taxpayers. The main method to reach these goals (based on a free market approach) is to increase demand for insurance, thereby increasing competition among insurers, who in turn are expected to use their market "clout" to constrain prices. Importantly, there is nothing in the Act that deals with rising costs or cost control: the focus is on using the insurance market as a tool to expand coverage.

The Act formed the Commonwealth Health Insurance Connector, (the "Connector") to help individuals and small businesses connect with health insurance products. It is, in essence, an insurance marketplace for employers and employees. The Connector is to "certify" that insurance policies meet certain standards of value and quality. Employees can purchase insurance (using pre-tax dollars under so-called "cafeteria" plans) and can access products of their choice within the Connector.

Any Massachusetts employer with 50 or fewer employees can designate the Connector as its group health plan. Employer-sponsored group health plans can choose to contract only with certain providers within the Connector if the products are Connector-approved.

The Employer Mandate and the "Fair Share Contribution": § 47 *Effective 10/1/06*

Employers with 11 or more full time employees (FTEs) who are NOT "contributing employers" must make an annual "fair share contribution" of up to $295 for each FTE. An FTE is an employee that works at least 35 hours per week. A "contributing employer" is an employer that makes a "fair and reasonable premium contribution" to the health insurance cost of its employees.

Under the DHCFP's proposed regulations, determining whether an employer makes a "fair and reasonable premium contribution" is based on the following two-part test:

1) If at least 25% of the employer's FTE's are enrolled in a health plan sponsored by the employer, then the employer is deemed to be making a "fair and reasonable premium contribution." The employer is required to calculate its enrollment percentage by dividing the total annual payroll hours of enrolled FTEs by the total annual payroll hours of all FTEs.
2) If the employer fails the 25% test, it may demonstrate that it makes a "fair and reasonable premium contribution" if it offered to pay at least 33% of the premium cost toward an Individual Health Plan for FTEs employed at least 90 days during the year.

Both tests are based on FTEs only and exclude part-time, seasonal, and temporary employees. A seasonal employee is an employee who works four months or less during the year, while a temporary employee is an employee who works full time for less than 90 days during the year.

If an employer fails both tests, it must pay the "fair share contribution."

Free Rider Surcharge: § 44 *Effective 10/1/06*
The "free rider surcharge" is imposed only when a "non-providing" employer's employees (or their dependents) receive free care from the Uncompensated Care Pool (state-funded care) more than three times a year, or when a "non-providing" employer's company has five or more instances of employees or their dependents receiving free care in a year. The surcharge ranges from 10% to 100% of the state's costs of services provided to the employees or their dependents that is more than $50,000. Under the DHCFP's proposed regulations, the surcharge percentage amount is determined based on the number of employees, the number of admissions and visits for free care, the percentage of employees for whom the employer provides health insurance, and the employer's compliance with the Health Insurance Responsibility Disclosure Requirement (discussed below). This surcharge could be a very significant amount.

A "non-providing employer" is an employer (i) of more than 10 employees who (ii) does not offer to contribute toward or arrange for the purchase of health insurance for its employees, and (iii) fails to maintain a cafeteria plan.

A "non-providing employer" excludes an employer that (i) offers to contribute or arrange for health insurance (including through the Connector), (ii) employs fewer than 10 individuals (note that it is unclear if this means 10 FTEs), (iii) is a signatory to bona fide collective bargaining agreement, or (iv) participates in the Commonwealth's Insurance Partnership (a program of state subsidies that helps qualified small businesses and lower-income employees pay for health insurance).

Internal Revenue Code § 125 "Cafeteria Plan" Mandate: § 48 *Effective 10/1/07*
Internal Revenue Code § 125 "cafeteria plans" permit employees to purchase their health insurance with pre-tax dollars. Each employer with more than 10 employees will be required to adopt and maintain a plan that satisfies § 125 and to file a copy of the plan with the Commonwealth in order to avoid being a "non-providing" employer. The employer will also need to provide access to group health coverage either under its own group health plan or through the Connector. This part of the Act is intended to shift some of the responsibility to employees as they will be able to use pre-tax dollars to pay for health insurance and health care services.

Health Insurance Responsibility Disclosure Form: § 42
Effective upon enactment but awaiting proposal of the actual HIRD Form
Employers are required annually to complete and sign, under oath, the "Health Insurance Responsibility Disclosure Form" (HIRD Form). The form indicates if the employer has offered to pay or arrange for the purchase of health insurance (including maintenance of a cafeteria plan) and if each employee accepted or declined such coverage.

Employees that either are not offered or decline employer-sponsored insurance or the employer's offer to purchase insurance are required to sign, under oath, an Employee HIRD Form indicating whether the employer offered insurance or to arrange for the purchase of it, and, if the employee declined, whether the employee has alternative insurance coverage.

Employers must submit an Initial HIRD Form by May 15, 2007 and must submit updates annually. Employers with 50 or more employees must submit quarterly updates. Compliance will require coordination between employers and employees.

Employer Coverage and Contributions – Non-discrimination: §§ 52, 55, and 59 *Effective upon enactment*
If an employer provides group health coverage to FTEs, then all FTEs who live in Massachusetts must be included. Employers are no longer allowed to make different health insurance premium contributions to different groups of employees. This mandate applies to BC/BS, PPOs, and HMOs.

Dependent Coverage: § 53 *Effective 1/1/07*
The Act requires family policies to provide extended cover-

age for dependents. At this level, there is a lurking income tax issue. Children are allowed to remain on their parents' health insurance plan until the first of turning 25 or 2 years past the loss of dependent status Notably, Internal Revenue Code § 152(c)(3) indicates that dependent status terminates earlier- at age 19 or 24 for students. Thus, children's health insurance costs could receive inconsistent treatment under federal and state tax law. Parents will be able to deduct the cost of a child's health insurance for state income tax purposes, but may not be able to deduct those costs for federal income tax purposes.

Individual Mandate: *Effective 7/1/07*
The individual mandate requires that, starting July 1, 2007, all residents of the Commonwealth over the age of 18 obtain and maintain "creditable coverage", a minimum level of health insurance coverage, based on a premium schedule published every December 1 that will have variations for age and rate.

Residents who fail to provide evidence of such coverage on their income tax return and do not qualify under an exception will lose their personal tax exemption. Failure to comply with the individual mandate for 2008 and beyond will result in a *penalty* of up to 50% of the monthly minimum insurance premium for creditable coverage.

A resident does not need to obtain coverage in compliance with the individual mandate where his or her refusal to do so is based on religious beliefs, a hardship based on criteria established by regulation, or a determination that no affordable coverage is available.

Conclusion

Some concluding points are worth noting. First, employers will undoubtedly incur some administrative costs to comply with the new law. Additionally, there is a real question whether the employer mandate will survive a challenge based on ERISA remains an open issue. Recently, a Maryland law was overturned by a trial court based on an ERISA challenge, and it is expected that appeals will be filed in that case. Third, the Act imposes a moratorium on the creation of new health insurance mandated benefits through 2008. Finally, the DHCFP will hold a public hearing on August 8, 2006 relative to the adoption of the regulations pertaining to the "Fair Share Contribution" and the Free Rider Surcharge. The DHCFP will hold a public hearing on August 15, 2006 relative to the adoption of the regulation pertaining to the HIRD Form.

We will continue to update you about this important legislation as it comes into focus.

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