

October 2006 LEGAL ALERT Notice:

Massachusetts Universal Health Care – A Primer for One State’s “Play or Pay” Rule

An estimated 46 million people in the United States do not have health insurance. As the uninsured population continues to grow, more of the responsibility for providing their care defaults to the states in which they reside. Responding to the increasing financial burden created by the uninsured, a number of states have passed or are considering legislative health insurance mandates.

Among the various states, Massachusetts’ “play or pay” approach appears to be the most ambitious. The Massachusetts universal health care law (the “Act”) is sweeping legislation to reduce the number of residents without health insurance. In an effort to expand insurance coverage, the Act imposes new mandates on individuals residing in Massachusetts and all employers operating in Massachusetts. Employers¹ with operations in Massachusetts, most of whom regularly conduct open enrollment in the fall, are anxious to learn how the Act will affect them so that they may, if necessary, make adjustments to their group health plans. Employers with no operations in Massachusetts are also watching with interest. They understand that if the Act (or portions of it) proves successful in addressing the uninsured problem in Massachusetts, they may be seeing variations of it in the states in which they do operate.

The Act is unique in that it imposes new requirements not just on employers doing business in Massachusetts, but also on all individuals residing in Massachusetts. The Act requires that all individuals residing in Massachusetts obtain and maintain health insurance. In addition, the Act requires employers to provide, arrange for and underwrite (in some cases) health coverage for their employees. This Alert reviews the key features of the Act and identifies important

concerns employers should consider immediately.

Background

In April 2006, Massachusetts Governor Mitt Romney signed into law “An Act Providing Access to Affordable, Quality, Accountable Health Care.” During the following months, a series of statewide hearings were held by the Massachusetts Division of Health Care Policy and Finance (“HCPF”) of the Commonwealth’s Executive Office of Health and Human Services. HCPF later released three proposed regulations (in June 2006) addressing the Act’s key features, the Fair Share Contribution, Free Rider Surcharge, and the Health Insurance Responsibility Disclosure (“HIRD”) form requirements. In September 2006, HCPF released final regulations for the Fair Share Contribution. In September 2006, HCPF announced that it was postponing publication of final regulations for (1) the Free Rider Surcharge, pending a decision by the Massachusetts legislature on whether to postpone its effective date, and (2) the HIRD requirements, pending further discussions about the ability to avoid interdepartmental duplication and concerns about identity theft. This Alert discusses the final regulations for the Fair Share Contribution portion of the Act, noting, as appropriate, differences from the proposed regulations. This Alert also discusses the proposed regulations for the Free Rider Surcharge and the HIRD requirements, but employers are advised that these proposed regulations are subject to change.

¹ The definition of *employer* is expansive and includes all employers of any kind doing business in the Commonwealth. As the law applies to *employers*, no distinction is made between those sponsoring self-insured or fully insured group health plans. In other words, while self-insured employers have been exempt from certain state mandates in the past, they are not exempt from this mandate.

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Individual Mandates

The Act requires all Massachusetts residents to obtain and maintain a minimum level of health insurance coverage, beginning July 1, 2007. This minimum coverage, referred to as “creditable coverage,” will be based on a premium schedule published each December 1 that will allow for variations for age and rate. Massachusetts residents will be required to confirm that they have health insurance coverage on their state income tax forms filed in 2008 (for calendar year 2007). Coverage will be verified through a database of insurance coverage for all individuals. This portion of the Act will be enforced by the Massachusetts Department of Revenue; individuals who fail to comply with the individual mandate in 2007 (and who do not otherwise qualify under a permitted exception, including religious beliefs, hardship and lack of available affordable coverage) will be faced with the loss of their Massachusetts state personal tax exemption.

For 2008 and beyond, failure to comply with the individual mandate will result in a penalty of up to 50% of the monthly “minimum insurance premium for creditable coverage” for each month the individual fails to have insurance coverage. This penalty will be first satisfied by forfeiture of available tax refunds (subject to higher statutory priority claims on use of refunds), and, if that amount is insufficient, direct assessment on the affected individual for the balance.

This approach is unique and is clearly the part of the Act that addresses most directly the problem the Act purports to solve—it requires individuals to purchase insurance and penalizes those who choose to rely upon state services for their health care needs.

Employer Mandates

In general, the Act imposes surcharges on certain employers based on the lack of insurance coverage for their employees. The Act also stipulates that employers must be contingently liable for the use of public health care services by their employees. The

employer mandates fall into three general categories: the Fair Share Contribution, the Free Rider Surcharge, and the HIRD requirements.

The Fair Share Contribution –

The Fair Share Contribution is an annual assessment against employers doing business in Massachusetts who employ 11 or more full-time equivalents (“FTE”) and who do not make a “fair and reasonable premium contribution” toward the health insurance coverage of their Massachusetts employees.

The Fair Share Contribution amount is derived from the annual per capita cost of persons who are accessing the Commonwealth’s uncompensated care pool or receiving unreimbursed physician services, but the amount cannot exceed \$295 per year per FTE employee.² The calculation is done annually (using an October 1 - September 30 fiscal year), beginning October 1, 2006. The annual “fair share contribution” will be the lesser of \$295 per employee or the sum of the “fair share employer contribution” and the “per employee cost of unreimbursed physician care.” The state will use a complex methodology for calculating these two components, but an employer’s liability will be capped at \$295 per person.

Payments for the fiscal year commencing October 1, 2006, and ending September 30, 2007, will be due by March 1, 2008. Employers may make installment payments quarterly prior to March 1, 2008.

An employer must make a fair share contribution if it does not make a fair and reasonable premium contribution toward the health insurance costs of its employees. Whether an employer makes a fair and reasonable contribution is determined using either (i) the “Primary” or “25% Test” or (ii) the “Secondary” or “33% Test.”

The Primary Test: The Primary Test is based on enrollment in a group health plan. If at least 25% of the employer’s full-time employees are enrolled in a health plan sponsored and paid for by the employer, then

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the employer is deemed to be making a fair and reasonable premium contribution. The percentage of employees covered for purposes of this test is determined by dividing the employer's total annual payroll hours of its full-time employees (defined in the Act as employees who work more than 35 hours per week) enrolled in its health plan by the total annual payroll hours of all of its full-time employees.

²This provision of the Act was passed over Governor Romney's veto.

If the 25% test is passed, the employer will be deemed to be making a fair and reasonable contribution and will not be required to pay the fair share contribution. Whether and to what extent certain individuals must be included in either the numerator (full-time employees participating in the employer's group health plan) or the denominator (full-time employees of the employer) will make all the difference to some employers. For example, assume an employer has 1,000 full-time employees and offers group health insurance. Also assume that 240 of the employer's full-time employees participate in the employer's plan, 100 receive their insurance from a spouse's plan and the remainder choose not to obtain insurance at all. This means that 34% of the employer's workforce is covered by insurance. The 100 who are receiving insurance (just not from this employer's plan) are included in the denominator but not in the numerator. Only the 240 who participate in the employer's plan are included in the numerator, however, and it will fail the Primary Test because only 24% of its workforce is covered by its group health plan. If the 100 employees covered elsewhere are not included in the denominator, the employer passes the Primary Test ($240/900 = 26\%$). If the Act is designed to promote health insurance coverage, it should consider all potential sources of coverage for this test and permit adjustments accordingly.

The final Fair Share Contribution regulations, released in September 2006, confirm that employers may exclude

independent contractors, seasonal employees and temporary employees from the calculation.

An independent contractor is an individual not deemed to be an employee under Massachusetts law because he or she is free from the employer's control and direction in performance of his or her services, as demonstrated not only by contract but also by the actual facts of the relationship. In addition, the individual must perform his or her services either outside the usual course of business for which the service is performed or outside of all the places of business of the enterprise for which the service is performed.

As drafted, the Fair Share Contribution regulations suggest that a contract with an independent contractor must state that the individual is not under the employer's direct control and direction in performance of the services. Employers who will rely on this exception should review existing independent contractor contracts and also audit their independent contractor practices to ensure that, in fact, they meet the test. In addition, the regulations do not make clear what "outside the usual course of business" means. Employers relying solely on this exception should consult with competent legal counsel to assist them in making this determination.

Seasonal employees must meet all parts of a four-part test. The employee must (1) be hired as a seasonal employee by a "seasonal employer" during the employer's seasonal period in its seasonal operations for a specific temporary seasonal period, (2) be notified by the Massachusetts Division of Unemployment Assistance that he or she is performing seasonal services for a seasonal employer, (3) be employed no earlier than the beginning of the seasonal period and no later than the end of the seasonal period, and (4) work no more than 16 weeks. An individual who fails any one of these four tests may not be excluded from the calculation as a seasonal employee.

Temporary employees can be either full- or part-time, but their employment must be explicitly temporary and they cannot work more than 12 consecutive weeks in the 12-

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month period starting October 1 and ending September 30.

The definition of “temporary employee” in the Fair Share Contribution regulations provided welcome relief for certain service sectors that found the language in the proposed regulations a bit disturbing. The proposed regulations defined a “temporary employee” as any individual who provided services for 90 days or more in the 12-month period beginning with October 1. For staffing companies and others, this definition was disconcerting, to say the least. The new definition in the final regulations should be, in most cases, easier to deal with for these entities.

There is a general misconception that the Primary Test directly mandates design changes. Instead, the Primary Test measures the percentage of employees who enroll in the employer-sponsored plan; it does not directly measure the amount of the employer’s contribution. This is an important fact for employers to consider. For example, employers who offer part of their workforce “mini-med” insurance, but pay no part of the premium, may want to consider whether a nominal employer contribution to a mini-med plan would be less costly than the \$295 per employee assessment. This, of course, should be considered only after it is determined the employer fails the Primary Test, and the mini-med meets the definition of a group health plan under the Act.

For purposes of the Act, employee leasing companies are entities that provide leased employees to contracting companies on a long-term basis (i.e., not seasonal or temporary) under contract, pursuant to which the leasing company maintains primary responsibility for personnel decisions, including hiring, firing and work site placement. Employee leasing companies, and not the contracting employer, must include their employees in its Fair Share Contribution calculation. Contracting employers who do not insure the leased employee cannot include them in their numerators but are also not required to include them in their denominators.

Multi-state employers, according to the Fair Share Contribution regulations, must include all full-time employees working at their Massachusetts facilities when they perform their Primary Test calculations.

The employer may exclude from the denominator any employee who has claimed an exemption from the application of the Act because of a “sincerely held religious belief” and has filed an affidavit with the Commonwealth. Unaddressed in both the proposed and final Fair Share Contribution regulations is a significant portion of almost every employer’s workforce—the employee who is covered under his or her spouse’s plan offered by the spouse’s employer. Spouses covered by other employers’ coverage will not show up in their employer’s numerator, but if they are full-time employees, they will show up in the denominator.

The Secondary Test: If the Primary Test is not met, the employer may nonetheless demonstrate that it makes a fair and reasonable premium contribution if it passes the Secondary Test by contributing 33% or more for the purchase of health insurance for its fulltime employees who work more than 90 days in a fiscal year.

An employer that cannot pass either test must pay the Fair Share Contribution on an annual basis. Employers should be talking with both their benefits legal counsel and their group health insurance broker or consultant immediately to determine whether and to what extent they will have difficulties passing either the Primary or the Secondary Test. Again, as the Act is effective on October 1, 2006, employers should work with their advisors to discuss and evaluate their options.

The Free Ride Surcharge –

In addition to the Fair Share Contribution, employers with 11 or more employees who are deemed to be “non-providers” are subject to a surcharge for “state-funded health costs” incurred by their employees and their respective dependents. As of mid-September 2006, HCPF had issued only

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proposed regulations with respect to the Free Rider Surcharge provisions of the Act. The following discussion is based only on the proposed regulations.

The employer surcharge will be imposed on non-providing employers whose employees and dependents cumulatively use \$50,000 or more of “state-funded” health services in a year. For the surcharge to apply, the \$50,000 threshold must be met and individual employees and their dependents must have three or more state-funded claims, or there must be five or more state-funded claims in the aggregate from an employer’s employees or their respective dependents in a year.

Surcharge assessments can range from 10% to 100% of the state-funded costs. The percentage of state-funded costs assessed will vary by the number of an employer’s FTEs. State-funded costs are the costs incurred for services to the employees of non-providing employers and their dependents that are paid from the Uncompensated Care Trust Fund or its successor. The amount of the assessment increases with the number of occurrences, the employer’s failure to comply with the HIRD requirements (discussed below), and the employer’s status as a repeat offender, if applicable. The assessment can decrease if the employer has a high percentage of full-time employees enrolled in employer-sponsored health insurance.

For purposes of assessing the surcharge, employers will be assigned to one of four categories, depending on the number of their employees, as follows:

Category # of Employees

1. 11 - 20
2. 21 - 40
3. 41 - 50
4. 51+

The assessment is based on a percentage of the state-funded costs for health services. Percentages are assigned to each of the categories, on a sliding scale.

An employer will not be deemed a non-provider if it offers to contribute toward, or arranges for the purchase of, health insurance coverage. It would appear that this mandates an employer to sponsor a cafeteria plan (a Code Section 125 plan) and to make coverage available through the Commonwealth Health Insurance Connector. If it does so, the employer will satisfy the “arranges for” requirement and be exempt from the surcharge. Employers with union employees that have entered into a collective bargaining agreement and those that participate in the Massachusetts Insurance Partnership, which provides subsidies for employer-provided health insurance for low-income individuals, are exempt from the surcharge.

The Health Insurance Responsibility Disclosure (HIRD) Form –

Like the Free Rider Surcharge rules, as of the date of this Alert, HCPF has only issued proposed regulations with respect to the HIRD requirements. Moreover, they have not released a Model Form. This discussion is based only on the proposed regulations. Under the proposed regulations, starting in 2007, every employer doing business in Massachusetts will be required to file an initial HIRD form that includes:

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

The proposed regulations required the initial form to be filed on May 15, 2007, based on employees employed as of April 15, 2007. Thereafter, smaller employers (49 employees

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or less) will be required to file subsequent forms annually, while large employers will be required to file quarterly.

A Note On Dependents –

In addition to the employer mandates, the Act also includes a new definition for “dependent” coverage in Massachusetts, effective January 1, 2007, that will impact fully insured plans. With this provision, Massachusetts joins a growing list of states that have expanded the definition of dependent for insurance purposes in an attempt to address the large number of twenty-somethings residing in their states who are not covered by insurance. Colorado (until age 25 if unmarried, financially dependent, or share the same permanent address as the insured), New Jersey (up to age 30) and Rhode Island (financially dependent students until age 25) have all revised or enacted new statutes defining coverage for dependents. In Massachusetts, the Act provides that dependents may remain on their parent’s coverage until the earlier of two years after the date they would otherwise lose dependent status under the Internal Revenue Code (“Code”) or age 25. HCPF has provided no guidance on the implementation of this provision, and many questions remain unanswered. However, employers should be talking with their benefits counsel now about amending their plans accordingly. Employers should also note that offering dependent coverage beyond the age specified by the Code will result in imputed income to their employees who cover these dependents, because the Code only exempts from income for federal tax purposes benefits provided by dependents as defined under the Code. Employers should be discussing with their payroll administrators the need to impute this income and how it will be reflected. They should also discuss with ERISA counsel the extent to which they should provide notice to their affected employees of this tax issue.

A Final Note –

Some ERISA practitioners have expressed concern about the Act and its “play

or pay” provisions, and concern that the law runs the risk of ERISA preemption. ERISA—the Employee Retirement Income Security Act of 1974—is a federal statute that governs employer-sponsored benefit plans, including group health insurance plans. ERISA has a very broad preemption provision that, in many cases, overrides any state law that “relates to” employer-sponsored benefit plans. ERISA excepts (saves) from preemption state insurance laws, but this exception, in general, typically does not exempt state laws that directly regulate employers in the operation of their benefit plans. ERISA’s preemption is designed, in part, to insulate employers in the operation of their benefit plans from 50 different sets of state laws, thus enabling them to offer comprehensive programs in the various states they operate, without fear that they will be required to make changes in each state in which they operate.

A few aspects of the Act may be subject to ERISA preemption challenge. For example, the Fair Share Contribution rules require employers to demonstrate that their group health insurance covers a significant portion of their full-time workforce or contributes at least 33% of the premium cost, or pay a significant per-employee penalty. This requires the employer to either (a) make their plan more attractive (and thus boost, presumably, their plan “take-up” rates), or (b) contribute more. In either case the Commonwealth is either indirectly or directly dictating to employers the benefits they should provide. In contradiction to one of the fundamental stated ERISA purposes, the Act will require employers to adjust their insurance programs for Massachusetts and will not be in a position to follow a nationally uniform scheme for plan administration (another fundamental goal of ERISA preemption).

The Act’s drafters and supporters contend that it will survive a preemption challenge because of the Supreme Court’s 1995 decision in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.* These supporters argue that it will have only an “indirect” economic

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influence, not unlike the surcharge at issue in Travelers; however, unlike the surcharge in Travelers, that was passed on to employers indirectly through hospital bills and indirectly caused employers to consider the carrier they should use, the Act assesses a penalty directly on employers and either indirectly or directly mandates the benefits they will need to provide. That distinction could be an important one when the federal courts ultimately address the ERISA preemption issue.

We note the U.S. District Court for the District of Maryland's decision in *Retail Industry Leaders Association v. James D. Fielder, Jr.*, Maryland Secretary of Labor, Licensing, and Regulations, released July 19, 2006, in which the court held that a Maryland law targeting Wal-Mart and requiring the retail giant to contribute a certain amount of premium for its workers' health insurance or pay a penalty, was preempted by ERISA. The court ruled that requiring Wal-Mart to either

"play or pay" would require it to make special arrangements for its health plan in Maryland. This, the court ruled, ERISA would not permit.

However, a federal court decision about the Act and whether all or part of it is preempted by ERISA is unlikely to happen before its required effective dates. So, while some practitioners predict that the Act is subject to attack under ERISA, employers should begin now to talk with their ERISA attorneys, brokers, consultants and third-party administrators, among others, to determine what changes they will be required to make to comply with the Act.

Peter Marathas, Jr.

pmarathas@klng.com

617.951.9072

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