MASSACHUSETTS HEALTH CARE REFORM ACT

Marcia S. Wagner, Esq.
Barry M. Newman, Esq.
The Wagner Law Group, PC
99 Summer Street, 13th Floor
Boston, MA 02110
Telephone: (617) 357-5200
Facsimile: (617) 357-5250
www.erisa-lawyers.com
www.wagnerlawgroup.com
marcia@wagnerlawgroup.com

TABLE OF CONTENTS

THE WAGNER LAW GROUP
A PROFESSIONAL CORPORATION

Massachusetts Health Care Reform Act

I. Overview

In April 2006, the Commonwealth enacted the Massachusetts Act Providing Access to Affordable, Quality, Accountable Health Care, more commonly known as the Massachusetts Health Care Reform Act (the "Act") which, among other things, requires most state residents to carry health insurance either through their employers or individually. The objective of the Act is to create near-universal health care coverage throughout the Commonwealth by covering the state's 500,000 uninsured residents. The Act attempts to do this by reducing the cost of health insurance through subsidies and state-sponsored programs. It also imposes: (1) a series of penalties on employers in Massachusetts; (2) mandates on individuals who reside in the state; and (3) several mandates on Massachusetts insurers and HMOs. In this paper we examine these provisions separately, based on the entities affected.

II. Employer Obligations

For employers, the five most significant obligations are:

- Adopting and maintaining a premium conversion plan;
- Filing Employer Health Insurance Responsibility Disclosure ("Employer HIRD") Forms;
- Collecting Employee Health Insurance Responsibility Disclosure ("Employee HIRD") Forms;
- Demonstrating the employer's Fair Share Contribution; and
- Providing Certificates of Creditable Coverage.

A. Premium Conversion Plans.

Under the Act, employers doing business in Massachusetts with more than 10 employees must, by July 1, 2007, adopt and maintain a cafeteria (a/k/a, Section 125 or premium conversion) plan that allows employees to pay their share of health care premiums with pre-tax dollars. The cafeteria plan must meet the federal requirements of the Internal Revenue Code ("IRC"), and IRS proposed regulations as well as those rules established by the newly-created state agency called the Commonwealth Health Insurance Connector Authority (the "Connector"). Employers will be required to file a copy of their premium conversion plans with the Connector.

If an employer fails to meet the premium conversion plan requirement it will be subject to the Free Rider Surcharge which is discussed in Section E below.

Federal Requirements:

In accordance with IRS proposed rules, Section 125 cafeteria plan must consist of a written plan document containing at least the following six elements:

- 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.
- The plan's eligibility rules regarding participation.
- 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.
- 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.
- 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.
- The plan year on which the cafeteria plan operates.

Connector Requirements:

The Connector has issued final regulations describing the cafeteria plan requirements as follows:

- The new requirements apply to premium only plans (also known as premium conversion plans).
- An employer need not offer healthcare flexible spending accounts.
- Employer contributions are not required and the employer is not responsible for any shortfall amount if an employee's salary is insufficient to pay his monthly premium.
- To determine if an employer has more than 10 employees and is subject to the Connector's rules, the regulations say that the total payroll hours for all Massachusetts employees, including vacation, sick, short term disability, overtime and holiday that occurred during the determination period of April 1, 2006 to March 31, 2007 must be determined then divided by 2,000. If the result is 11 or more, the employer is subject to the cafeteria plan requirement. The regulations define an employee as "any individual employed by any employer at a Massachusetts location whether or not the individual is a Massachusetts resident." Therefore, any employees employed at an employer's Massachusetts location(s) must be allowed to participate in the cafeteria plan even if they do not live in Massachusetts.
- The plan must, at a minimum, offer access to one or more "medical care coverage options" in lieu of regular cash compensation. The Connector does not define the term "medical care coverage option" but presumably this would include the employer's own

health care plan or a Connector program. (These programs are discussed in Section III C.)

- The plan may have a waiting period that cannot exceed two months or, if less, any waiting period that corresponds with the waiting period for enrollment in medical care coverage options available under the cafeteria plan. However, under the Connector regulations, a plan may have a special initial waiting period for all eligible employees who are employed on July 1, 2007 that can last until September 1, 2007.
- Under the Connector regulations, the cafeteria plan may exclude:

    - Employees who are less than 18 years of age.
    - Temporary employees.
    - Part-time employees working, on average, fewer than 64 hours per month (approximately 16 hours per week) for an Employer.
    - Employees who are considered wait staff, service employees or service bartenders and who earn, on average, less than $400 in monthly payroll wages.
    - Student employees who are employed as interns or as cooperative education student workers.
    - Employees whose employer is required to contribute to a multiemployer health benefit plan based on their employment.

The law requires all cafeteria plans to be submitted to the Commonwealth. Hoqwever, the Connector has has issued an Administrative Bulletin delaying the filing of cafeteria plan documents until October 1, 2007, at the earliest.

Issues Raised:

The Connector's regulations have raised a number of critical questions that need to be answered. For example, is the Connector insisting on having certain individuals participate in the premium conversion plan when they are unable to make any pre-tax contributions to the employer's underlying health care plan? If an employee works 65 hours per month but the employer's group health care plan requires 20 hours per week for participation, is the employee entitled to make any salary reduction contributions, and if so, to what plan?

The instructions and regulations from the Connector are not the model of clarity (or consistency), but based on the regulations, and our conversations with members of the Connector, it would appear that the Connector will interpret its own regulations to say that each and every employee (other than those who can be excluded under the Connector regulations) must be offered access to the employer's group health plan or some other health care coverage option. For most employees, the primary option would be a pre-tax contribution to the employer's regular medical and/or dental plan. However, for employees who are not eligible for the employer's plan, the option could be the health care program they select from the Connector.

Although the alternative coverage to the employer's own health care plan would not have to be the Connector programs, there are, as the Connector notes, "several advantages in doing so". These include:

- employees may select from several Commonwealth Choice options;

- the options are approved by the Connector (that is they have been given the Connector's seal of approval);
- employees can enroll in any of the programs by contacting the Connector; and
- the Connector claims that its billing process is streamlined for the employer.

As for this last bullet, the Connector says that employers will simply withhold contributions from employees' paychecks and remit the contributions on a monthly basis to the Connector. It appears that the Connector will receive the employer information from the employees' application for and each employer will only receive one monthly bill. However, details of the employer payment program have not yet been announced.

A separate issue to consider is that there are some instances in the Connector's regulations and its model plan document where it is not clear that the Connector is complying with federal law.

Specifically, you should be aware of two of the most significant issues which are described below:

1. Eligibility. The rules regarding eligibility for the Connector programs are complicated and in many respects are unclear. The Connector's website states that all residents of Massachusetts and those employed by Massachusetts employers and who are 19 or older are eligible for the Connector programs. However, the Act restricts eligibility to those individuals who are residents of Massachusetts if the individual is not offered subsidized health insurance by an employer with more than 50 employees. In light of this discrepancy, we recommend that you do not respond to any questions regarding eligibility for the Connector. Rather, we recommend, that the employer suggest that the employee contact the Connector directly at 1-877-MA-ENROLL (1-877-623-6765) or at http://www.mass.gov/?pageID=hichomepage&L=1&L0=Home&sid=Qhic.

2. Mid-year Elections. Under the federal cafeteria plan rules, employees cannot make mid-year changes to cafeteria plan salary reduction elections unless there has been a "status change event" such as the birth of a child, a spouse's open enrollment, or a curtailment of health care coverage. Under these rules, an employee who terminates employment but returns within 30 days must have his old election reinstated. Therefore, an employee who elected not to make pre-tax contributions and who left the job for fewer than 30 days would be bound by his election under federal law. However, under the Connector's rules, this individual would be required to be given the opportunity to elect pre-tax contributions.

Because the Connector's eligibility and election rules under its cafeteria plan requirements differ from that of the typical premium conversion plan, and some of these rules may not be in accord with federal rules for cafeteria plans, the simplest way to keep technical and administrative problems to a minimum would be to have each group (those participating in the employer's group health plan and those who are participating in a Connector program) placed in different premium conversion plans.

Consequently, we would suggest the use of a separate document for those employees who are not eligible for the employer's health care plan. This would eliminate unnecessary conflicts between the two sets of rules. Also, given the uncertainties of this new Connector premium conversion plan requirement, a stand-alone plan would ensure that any problems with the current Connector rules do

not in any way jeopardize an existing cafeteria plan. Also, in this case, the new Connector plan would have no effect whatsoever on employees who already participate in the employer's currently sponsored group health care plan and premium conversion plan.

However, we would not recommend using the Connector-provided model 125 plan. Along with the issues previously discussed, the model is designed in a manner under which the Connector option is either the only option for all employees who elect out of the employer's plan or under which the employer's actual health care plan is an incidental benefit. This model also creates unnecessary options for the employees and will increase employer's administrative and communication burden.

Finally, it is significant that employers do not appear to have any communication requirements with respect to the establishment of the Connector premium conversion plan, other than offering coverage during election periods, since the Act has no such requirement and premium conversion plans are not covered by ERISA and therefore not subject to its reporting and disclosure requirements. Also, the Connector has made it clear that the employer is not a sponsor of the Connector program. In addition, the employer would not be required to assist employees in enrolling themselves or their dependents in a Connector program. Instead, employees should, once again, be instructed to contact the Connector directly.

B. Employer HIRD Forms.

In addition to the cafeteria plan requirement imposed on employers under the Act, employers with more than 10 full time employee equivalents (an employee equivalent is 2000 payroll hours, including vacation and sick leave, equaled a full time equivalent employee) doing business in Massachusetts must file information about the health coverage they provide to their employees on an Employer HIRD Form.

The Massachusetts Division of Health Care Finance & Policy (the "Division") has issued regulations listing the information that is required on the Employer HIRD Form. This information, which is to reflect the employer's situation as of July 1, includes:

- Employer's legal name, employer's d/b/a name, federal employer identification number and Division of Unemployment Assistance account number;
- Whether the employer offers a premium conversion plan that meets both federal and state requirements.
- If the employer offers an employer sponsored plan, its open enrollment period.
- Whether the employer contributes to the cost of group health insurance for its employees and, if it does:
    - the contribution percentage for each employee category if the percentage varies by category
    - the total monthly premium cost for the lowest priced health insurance offered for an individual and for a family
    - the highest monthly premium for an individual and for a family

The Division has stated that it will not issue a separate Employer HIRD Form but that employers will be required to submit the Employer HIRD information to the Division of Unemployment Assistance. The Division will notify employers about the method of submitting the Employer HIRD information and the due date for the submission at a latter date.

C. Employee HIRD Forms.

Each Massachusetts employer required to file an Employer HIRD Form also had to collect signed Employee HIRD Forms from each employee who declines:

- Employer-sponsored health coverage; or
- Participation in the employer's premium conversion plan.

Under the regulations, employers have to obtain signed Employee HIRD Forms within 30 days after the close of the open enrollment period for the employer's health insurance and/or its premium conversion plan, or if earlier, September 30 of the reporting year. For new hires, the Employee HIRD Form would have to be signed within 30 days of their open enrollment period. If an employee terminates participation under the employer's plan the employee must sign the HIRD Form within 30 days of the date of participation termination. However, under a transitional rule, if an employer's open enrollment period for 2007 through 2008 ended prior to July 1, 2007 and an employee has signed an employer form acknowledging that she or she was offered and declined employer sponsored coverage, that employee is not required to sign an Employee HIRD form until after the next applicable open enrollment period occurring after June 30, 2007.

The regulations contain a draft Employee HIRD Form. However an employee may collect the required information and acknowledgements "in any form or manner, including any electronic or other media that it deems necessary or appropriate."

If an employee failed to return the signed form, the employer would have to document diligent efforts to obtain the signed Employee HIRD Form and maintain the documentation for three years. The Employee HIRD Forms would have to be made available to the Division upon request.

The regulations require the following:

> (a) Required Information. Each employee is required to submit the following information:
>
> 1. Employee name
> 2. Employer name
> 3. Whether the employee was informed about the employer's premium conversion plan
> 4. Whether the employee declined to use the employer's premium conversion 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 date the employee completes and signs the HIRD form

(b) 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 premium conversion 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 health insurance mandate 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.

D. Employer's Fair Share Contribution Test.

Massachusetts employers with more than 10 employees that fail to make a "fair and reasonable" contribution toward the cost of health coverage must pay an annual "Fair Share Contribution" not to exceed $295 per employee. To be exempt from the requirement to pay a Fair Share Contribution, the employer must pass one of the following two tests:

- *25% Test.* The employer's health insurance plan must cover at least 25% of its full time employees employed at Massachusetts locations whether or not they are Massachusetts residents, for the period from October 1 through September 30 of each year. For purposes of this test a "full time employee" is defined as an employee who works at least 35 hours per week. This test is not affected by other coverage an employee may have. For example, if an employee is covered by a spouse's plan this will not count towards meeting the 25% test.

- *33% Test.* An employer that fails the 25% test must pay at least 33% of the premium cost for all of its Massachusetts employees who are covered by employer-provided insurance regularly scheduled to work at least 35 hours per week and who work at least 90 days during the period October 1, 2006 through September 30, 2007.

In accordance with the final regulations, each employer will have to file or make available information that will enable the Division to calculate the Fair Share Contribution. The Fair Share determination rules are effective October 1, 2006, and the initial reporting obligation is for the period ending on September 30, 2007.

Surprisingly, these regulation have very little to do with "Fair and Reasonable" contributions. More importantly, they do not establish any criteria for the type of health insurance coverage that the employer must provide. In fact, it appears possible that an employer can provide minimal insurance that does not even meet the criteria for "creditable coverage" (as discussed in the Individual's Obligations section of this paper) and still meet this Fair Share Contribution test. Presumably, if this were to occur, the employees would be obligated to purchase their own insurance through the Connector in order to meet their own health insurance coverage requirements under the Act.

Employers will demonstrate that they have met the Fair Share Contribution tests through the submission of the HIRD Form.

E. Free Rider Surcharge.

Effective July 1, 2007, in addition to the Fair Share Contribution, an employer with more than 10 employees that does not conform to the premium conversion plan rules, can be assessed a "free rider surcharge" if five or more of its employees or their dependents use free health care during a year or if one employee or his or her dependents uses state-funded care more than three times in a year. The surcharge ranges from 20% to 100% of the Commonwealth's costs for these services, depending on this size of the employer, the usage of free health care by the employer's employees and the percentage of employees for whom the employer provides heath insurance. However, the first $50,000 of health care provided to the employer's employees is been exempt from the surcharge.

In addition, each employer is required to file or make available information required by the Division to calculate and collect the surcharge. If an employer failed to provide information within two weeks after receiving written notice or falsified information, the employer would have been subject to a civil penalty of not more than $5,000 for each week on which such violation occurs or continues.

F. Creditable Coverage Certificates.

Effective January 1, 2008, employers (and insurers) must issue certificates of creditable coverage similar to those required by the portability provisions of the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Failure to provide the certificates could result in penalties of $50 per individual up to $50,000 per year.

The Commonwealth has not yet issued guidance on the creditable coverage certificate requirement but it would appear, at least at this point, that compliance with the HIPAA certification requirement would be sufficient to meet the state certificate requirement as well.

III. Individuals' Obligations

A. Basic Requirement.

The law requires almost all residents of the Commonwealth to have health insurance, defined as "creditable coverage", either acquired through their employer or purchased on their own, by July 1,

2007. Those individuals who do not obtain insurance through their employer may purchase it through the Connector, which will have the task of connecting individuals and small groups with insurers. To date, the Connector has established two programs, the Commonwealth Care program which consists of subsidized coverage for individuals with limited income and the Commonwealth Choice program, which is available to individuals regardless of income. A third program, small group program, which will be available through Commonwealth Choice has not yet been rolled out.

Individuals will be required to state that they are covered by health insurance on their state income tax forms for 2007. If they cannot do so, they will lose their personal exemption for state income tax purposes. For 2008, the penalty can be up to half of the monthly cost of the minimum required insurance.

B. "Creditable Coverage" Defined.

The Connector has issued regulations defining creditable coverage. Under the regulations, individuals will generally have to have health care coverage with a maximum deductible of $2,000 on individual insurance and a $5,000 annual limit on out-of-pocket spending. These numbers are doubled for family coverage. There would be an exception to the deductible limits for high deductible health plans that meet the federal rules for health savings accounts. In addition, all health care coverage would have to include prescription drug coverage with an additional, maximum individual deductible of $250 for individuals and $500 for families.

However, the Connector also decided that these rules would not be effective until January, 2009 to give individuals, employers and insurers additional time to meet these creditable coverage requirements. In the meantime, individuals must have at least a minimum level of coverage by July 1 to avoid the loss of the personal income tax exemption. This minimum coverage would include any individual or group policy of health, accident and sickness insurance, or any self-funded health plan, including any of those that which meet the definition of an employee welfare benefit plan under ERISA. Because ERISA has no benefit limits, any health plan providing any amount of health care benefits will be acceptable for the first year.

Should these creditable coverage regulations be finalized, even the 2009 requirements should cause little disruption, for most employers that are already providing their employees with health care benefits, since just about all but the least generous of health care plans will meet the standards, although some will need prescription drug riders.

C. Connector Programs.

The Commonwealth Care Health Insurance Program (Commonwealth Care) is run by the Connector. It connects eligible Massachusetts residents with approved health plans and helps residents pay for such plans. Commonwealth Care is an insurance program for uninsured individuals with incomes that fall within certain guidelines and who meet other qualifications.

Commonwealth Choice is a health insurance program that is administered through the Connector. Coverage under Commonwealth Choice will be through a variety of affordable, private

health insurance plans. The Connector will help individuals and small group employers choose, purchase, and enroll in appropriate health plans.

The Connector is offering four levels of coverage under Commonwealth Choice, including Premier, Value, Basic, and Young Adult. These four levels are designed to meet the needs of different individuals and families.

To enroll in a Commonwealth Choice health plan, individuals and/or employers must pay a monthly premium. The premium will depend on the health plan and benefit package chosen. Commonwealth Choice members must pay a fee (co-payment) each time they use some Commonwealth Choice benefits. In addition, there may be a deductible (an amount that the member must pay out of pocket for services before the health plan begins paying). This amount will vary by health plan and there will be different family and individual out-of-pocket maximum amounts.

D. Affordability.

Individuals who do not obtain insurance through their employer may purchase it through the Connector and may receive a subsidy for their heath insurance coverage. Under the original rules, those who were under the federal poverty level would receive Commonwealth Care health coverage at no cost, while those who earn up to 300% of the poverty level would have subsidized coverage based on income.

For 2007, 300% of the federal poverty level is approximately $29,400 for an individual and $60,000 for a family of four. Consequently, the Connector received complaints that many individuals would be penalized simply because they would be unable to afford the insurance coverage. In response, the Connector has agreed to issue new affordability standards.

For example, it is expected that for this year individuals earning 150% of the poverty level (rather than 100%) would be receive health care coverage at no cost, while those who earn up to 200% of the federal poverty level would have premiums for Commonwealth Care insurance reduced from $45 to $35 per month.

Individuals who are eligible for employer-provided health care do not appear to be currently eligible for subsidized insurance through the Connector. In a significant move, the Connector has recommended that affordability provisions also be applied to these individuals as well. For example, in the proposal, a single individual earning between $40,001 and $50,000 would not be penalized for rejecting employer provided coverage if the monthly premium is more than $300.

This last recommendation is particularly important because it will help to eliminate the pressure on employers to offer additional, low cost health plan options designed to be affordable by lower-paid employees who are required to meet the individual coverage mandate.

IV. Insurers' Obligations

A. Non-discrimination Rules.

Effective July 1, 2007, group health insurance policies or contracts (including HMOs and Blue Cross Blue/Shield, but excluding stand-alone dental plan arrangements) cannot be issued or delivered in Massachusetts unless the employer offers the insurance to all full-time employees "who live in the Commonwealth." In addition, under the Act, the employer cannot contribute a smaller percentage of the insurance premium for one employee than it does for another employee who receives an equal or greater salary. The Massachusetts Division of Insurance has recently issued its first guidance on this provision of the law.

The guidance defines full time employees to mean employees who work at least 35 hour per week and who are expected to work more than 12 consecutive weeks. The non-discrimination requirement is met if the employer contributes *either* a fixed percentage or a fixed dollar amount for all full time employees. However, the employer may contribute different amounts for different plan options (e.g., if the employer has an indemnity and HMO options or offers individual and dependent coverage). The rules also say an employer can have different contribution levels based on length of service or for employees who participate in health and wellness programs.

It is important to note that it is the insurer, and not the employer, that is responsible for compliance with this provision and will, in the absence of further guidance from the Division of Insurance, be responsible for determining the application of this non-discrimination rule. Please note that policies issued in another state that cover residents of Massachusetts may also be required to comply with the non-discrimination rule.

B. Dependent Coverage.

Effective January 1, 2007, group health insurance policies and contracts (including HMOs and BlueCross/Blue Shield) are required to cover dependent children for the first two years after they can no longer be claimed as dependents for federal income tax purposes or until they reach the age of 26, whichever occurs first. For purposes of the first rule, the two-year period will begin on the first day of the calendar year following the last year that the employee claims the child as a dependent on IRS Form 1040.

Bulletin 2007-1, issued by the Massachusetts Division of Insurance, explains that a dependent must be covered for two years after the "loss of dependent status" or until age 26, whichever comes first. The Bulletin clarifies that the "loss of dependent status" occurs on January 1 of the first year for which the individual can no longer be claimed as a dependent[1] on the employee's (or in some cases employee's spouse) federal tax return for that year. In one example, a dependent permanently leaves home on November 1, 2006, and she can still be claimed as a dependent on the employee's Form 1040

[1] In general terms, dependent means any individual who is the taxpayer's "qualifying child" or "qualifying relative". Generally, a qualifying child, must: (i) be the taxpayer's child or a descendant of such a child, or the taxpayer's brother, sister, stepbrother, or stepsister or a descendant of any such relative; (ii) live with the taxpayer for more than one-half of such taxable year; (iii) be under the age of 19 or a student who is under the age of 24, as of the close of such calendar year; and (iv) not provide over one-half of his or her own support for the taxable year. A qualifying relative must: (i) receive over one-half of his or her support from the taxpayer; (ii) have income that does not exceed $3,400 for 2007; and (iii) not be a qualifying child of the taxpayer or of any other taxpayer. In addition, the qualifying relative, must be a child of the taxpayer; descendant of a child; a brother, sister, stepbrother, or stepsister; the father or mother, or an ancestor of either; the stepfather of stepmother; a niece or nephew; aunt or uncle; a son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, or sister-in-law; or an individual who, for the taxable year, has the same principal place of abode as the taxpayer and is a member of the taxpayer's household.

for 2006 but not for 2007. Therefore, for purposes of the Act, the loss of dependent status would begin on January 1, 2007.

The Bulletin also gives examples of the dependent status rules when a dependent returns to dependent status, saying the two-year period begins again should the dependent again lose dependent status. It also says that if a dependent has a child of her own, the insurer (under other laws) must cover the child of the dependent. However, if the dependent loses dependent status, the grandchild does not have the right to be covered for the following two-year period.

The Bulletin also discusses the relationship between the extended coverage under the Health Care Reform Law and both state and federal COBRA. (The state law applies to employers with 2 to 19 employees, COBRA to those with 20 or more.) Surprisingly, the Bulletin says that for both federal and state law "the qualifying event will be the earlier of the 26th birthday or the date two years after the loss of continuation dependent status." This means that, according to the state, some people will be entitled to five years of continuation coverage (two years under Act's dependent coverage provision and 36 months under federal or state COBRA). However, while this part of the Notice may apply to state law, the state has no jurisdiction to rule on the application of federal COBRA. Only the IRS is authorized to make such a determination.

There does not appear to be any requirement under this dependent coverage provision that the employer continue to make contributions for dependents who are no longer covered under the plan. Thus, if your plan so provides, the former dependent child may have to pay the entire cost of coverage. However, if an employer does provide a contribution for individuals who are no longer dependents as defined under the Internal Revenue Code, the amount of the subsidy will be considered to be imputed income for the employee.

IRS has never ruled on how these subsidies should be valued. However, in instances such as this, the IRS will generally accept any reasonable method of valuation. For example, if you have domestic partners in your plan, you may want to use the same method for valuing subsidized health care coverage as is used for them. If not, you could use the COBRA rates, but many employers are hesitant to do so because they think the rates are too high for imputed income. Often employers simply ask the insurer or HMO for an appropriate amount. While all these methods of valuing the former dependent's health care coverage may be accepted, unfortunately, none have official IRS approval.

VI. Conclusion

Another issue yet to be determined is whether, and to what degree, the Massachusetts law will be preempted by ERISA. In general terms, ERISA "preempts" (that is, negates) any state law that "relates to" or "has a connection with or reference to" an ERISA-covered plan. Some employers have argued that the Massachusetts law, in practice, forces employers to create an ERISA-covered plan; dictates, to a certain extent, the level of employer contributions that are required for the plan; and, through the cafeteria plan requirements, interferes with the administration of an ERISA-covered plan. Therefore, they argue, ERISA preempts the Massachusetts law.

The ERISA preemption issue must ultimately be resolved in the courts, likely the U.S. Supreme Court. However, many, if not all, of the new law's provisions are likely to be in effect before it can be tested in the courts. Consequently, employers should be prepared to comply with the Massachusetts law's provisions, at least for the next few years, and possibly on a permanent basis.

The new health care law was written in an effort to extend health coverage to the majority of Massachusetts residents. However, as you can see, the law is quite extensive and there are many rulings that have yet to be issued and questions that remain to be answered. Naturally, we will be glad to help you in your efforts to understand, and comply, with the various aspects of this very complicated new law.

A0010441