SIGNIFICANT RECENT CHANGES IN TITLE I OF ERISA AND OVERVIEW OF MASSACHUSETTS HEALTH CARE LAW

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TABLE OF CONTENTS

Page

I. HIDDEN FEES

In a recent report to Congress, the United States Government Accountability Office ("GAO") concluded that American workers need to be more aware of the fees that they pay through their 401(k) plans. In a letter responding to the GAO report, the Department of Labor generally concurred with this view and indicated that it was reviewing regulatory steps that might be taken to improve the disclosure of plan fee and expense information to plan participants in order to enable them to make informed investment decisions.

Currently, there is only a limited duty to disclose plan fees and expenses to participants, and such disclosure applies primarily when plan sponsors seek protection under special regulatory rules that afford relief from liability from investment losses resulting from participants' investment decisions (i.e., ERISA §404(c)). Under these regulations, a participant must automatically be provided with a description of any transaction fees and expenses which affect the participant's account balance in connection with purchases or sales of investment alternatives. A participant in such a plan may request the latest expense ratio as well as the annual operating expenses of each mutual fund or other investment alternative offered by the plan. For purposes of meeting these requirements, many plans furnish participants with copies of mutual fund prospectuses which, in accordance with SEC regulations, disclose items such as mutual fund expense ratios. The Department of Labor is currently giving active consideration to expanding the applicability of the current rules to all participant-directed account plans.

At the present time, 401(k) plans typically do not separately disclose revenue sharing amounts to plan participants. Revenue sharing is the practice engaged in by mutual funds or other investment providers of paying other plan service providers, e.g., the plan's recordkeeper, for performing services that the mutual fund might otherwise be required to perform. A not unexpected by-product of the increased public and regulatory interest in 401(k) plan fees and expenses has been the filing of lawsuits against some of the nation's largest employers charging, among other things, that they breached their fiduciary duties by failing to monitor revenue sharing payments or to establish and follow procedures to determine whether such payments were reasonable. Some of the complaints also allege that the failure to disclose to plan participants all of the hard dollar and revenue sharing payments made directly or indirectly by plans was a fiduciary breach.

Proposed regulatory changes will, in all likelihood, raise the standard for what is viewed as reasonable disclosure to plan participants. For example, the Department of Labor has proposed changes to Schedule C of the Form 5500 that would apply for the 2008 plan year and would require reporting of virtually all payments to plan service providers by third parties in connection with the provision of services to the plan. The Department is also developing a revision of its prohibited transaction regulations that is likely to require up-front disclosure to the plan fiduciary by a plan service provider of information sufficient to enable the plan fiduciary to determine whether the plan is paying reasonable fees for services and whether any potential conflicts of interest affect the service provider's advice. For its part, the GAO has called on Congress to consider legislation that would amend ERISA to explicitly require 401(k) service providers to disclose compensation that they receive from other service providers. The GAO also proposes that plan sponsors be required to disclose fee information to participants in a way that facilitates comparison among the plan's investment options.

II. QUALIFIED DEFAULT INVESTMENT ALTERNATIVES

Sponsors of participant directed 401(k) plans are not responsible for the specific investment decisions made by participants if a plan complies with Department of Labor regulations mandating a broad array of investment alternatives and disclosure with regard to those alternatives. For years beginning after December 31, 2006, the Pension Protection Act ("PPA") extends this protection to situations where a plan makes investments in certain default investment alternatives notwithstanding the fact that a participant has failed to provide investment direction. On September 27, 2006, the Department issued proposed regulations that stipulated the conditions for such relief.

The proposed regulations relieve plan fiduciaries of liability for loss or for an ERISA fiduciary breach that results from investing part or all of a participant's account in a qualified default investment alternative ("QDIA"). A QDIA consists of one of the following three types of investment products or services:

- An investment fund product or model portfolio designed to provide varying degrees of long-term appreciation and capital preservation through a mix of equity and fixed income exposures based on the participant's age, target retirement date, or life expectancy, such as a life-cycle or target retirement product offered by a mutual fund;

- A balanced fund or balanced model portfolio designed to provide long-term appreciation and capital preservation through a mix of equity and fixed income exposures consistent with a target level of risk appropriate to participants in the plan as a whole; and

- An investment management service in which an investment manager allocates the assets of a participant's individual account to achieve long-term appreciation and capital preservation through a mix of equity and fixed income exposures offered through investment alternatives based on the participant's age, target retirement date, or life expectancy (e.g., an aged-based managed account).

The most controversial aspect of the proposed regulations is their failure to include a stable value fund in the mix of QDIA alternatives. The politicization of this issue has caused the Department to miss the PPA mandated target date (February 17, 2007) for issuing final regulations, and it is not clear when the final rules will be published. Nevertheless, because of the Department's policy objective of enabling participants to accumulate benefits at a rate that exceeds inflation, it is likely that the three alternatives already included as QDIAs will, because of their significant equity component, continue to be included in the list of QDIA products even if a stable value fund is added.

Whatever the outcome, plans may continue to use money market and stable value products as default options in accordance with pre-2007 law, although this will not ensure relief from fiduciary liability. Employers wishing to take advantage of the new protections for default investments will need to select qualifying investment products and amend their plans to require appropriate disclosure to participants, and, if necessary, remove any provision that would prevent

the use of a QDIA as a default investment. Moreover, fiduciaries will remain responsible for the prudent selection and monitoring of a QDIA.

Another disputed provision in the proposed regulations involves a requirement that a QDIA must be managed by either an investment manager, as defined by ERISA, or an investment company registered under the Investment Company Act of 1940. The ERISA definition of investment manager restricts this role to a fiduciary who is a registered investment adviser, a bank, or an insurance company that has the power to manage, acquire, or dispose of plan assets and has acknowledged its fiduciary status in writing. This definition would have the effect of prohibiting any trustee or named fiduciary of a plan, including the plan sponsor, from managing a QDIA for that plan. Thus the proposed rule, as it now stands may limit the role of certain independent investment consultants who would otherwise anticipate advising an employer with regard to the in structure and operation of one or more QDIA asset allocation strategies.

III. INVESTMENT ADVICE

ERISA imposes a number of substantial duties and restrictions on "fiduciaries." To foster the provision of investment advice to participants in participant directed account plans, the recently enacted Pension Protection Act extends exemptive relief to a "fiduciary adviser" from the application of the prohibited transaction rules as a result of engaging in an "eligible investment advice arrangement." Under the new rules, a "fiduciary adviser" is defined as a person who is a fiduciary by reason of providing investment advice and who is a registered investment advisor, bank, insurance company, broker dealer, and any of their affiliates, and all of their employees and agents. The exemptive relief is further conditioned on a written acknowledgement by the fiduciary advisor of its fiduciary status. This relief is effective for advice rendered after December 31, 2006.

There are two approaches by which a fiduciary adviser can offer an eligible investment advice arrangement: (1) the so-called "level fee" option under which the advisor's fees may not vary based on the selection of investment options, and (2) arrangements under which advice is based solely on a computer model, in which case fees to an advisor and its affiliates may vary. Under the second alternative, the computer model must use generally accepted investment theories, utilize relevant participant information (such as age, target retirement date, life expectancy and risk tolerance), be objective and unbiased, and consider all investment options under the plan in specifying how a participant's account balance should be invested without any inappropriate weighting with respect to any investment option. The model must also be periodically certified by an "eligible investment expert" as meeting the forgoing requirements, and the expert must not have any material affiliation or contractual relationship with the fiduciary advisor.

Eligible investment advice arrangements are subject to the following additional conditions: (1) the arrangement must be expressly authorized by a plan fiduciary other than the fiduciary adviser, (2) the fiduciary adviser is subject to an annual audit demonstrating compliance with the exemption, (3) there must be comprehensive disclosure to participants and beneficiaries by the fiduciary adviser of past investment performance by the plan's investment options, potential conflicts of interest, and fees or other compensation to be received by the

fiduciary adviser or an affiliate (including compensation from third parties), and (4) investment transactions entered into on the fiduciary adviser's recommendation are on arms' length terms and for reasonable compensation.

The new fiduciary advisor rule created an ambiguity as to whether prior Department of Labor guidance on the subject of fiduciary advice remained viable. Field Assistance Bulletin 2007-1 has now answered this question in the affirmative. This guidance also addressed the standards for selecting and monitoring a fiduciary adviser. Thus, plan fiduciaries have a duty to prudently select and monitor a fiduciary adviser that provides investment advice under an eligible investment advice arrangement, although the plan fiduciary is not required to monitor the advice given. According to the Department, a fiduciary should periodically review (1) the extent to which there have been changes in the information that served as the initial basis for the selection of the fiduciary adviser, (2) whether the advice being furnished was based on generally accepted investment theories, (3) whether the fiduciary adviser is complying with the contractual provisions of the engagement, (4) the utilization of the investment advice by participants in relation to the cost for such services, and (5) participant comments and complaints about the quality of the advice.

IV. REPORTING AND DISCLOSURE REQUIREMENTS

A. *Funding Status*. Beginning in 2008, plan administrators of defined benefit plans will be required to send annual notices to participants, beneficiaries, the PBGC, and unions providing detailed information on plan funding. The notice must disclose the value of the plan's assets as compared to liabilities for the current year and the two preceding plan years, its funding status, its funding policy and allocation of investments, a summary of the rules governing termination, and a description of those benefits guaranteed by the PBGC. This requirement is similar to the current rule for multiemployer pension plans which will be required to provide additional information as to whether the plan is in endangered or in critical status.

The notice must be provided within 120 days after the end of the plan year to which it relates, although plans with fewer than 100 participants will not have to provide it until the Form 5500 annual report for the year is due. The Department of Labor will publish a model notice within one year of the enactment of the PPA (i.e., by August 17, 2007).

> **Comment**: Employers should review the funding status of their defined benefit plans under the new rules and determine how this information will affect their employees. In some cases, it will be important to educate employees about their plans before the notice is issued in order to ensure that they understand the information being provided and do not become unnecessarily alarmed.

B. *Notice to PBGC of Underfunding*. Beginning in 2008, the plan sponsor of a plan that is less than 80% funded for the preceding plan year under the rules described above must file additional funding information with the PBGC.

C. *Repeal of Certain Notice Requirements*. Beginning in 2008, defined benefit plans subject to Title IV of ERISA will no longer be required to furnish a summary annual report

("SAR") to participants. Effective as of 2007, the PPA also repeals Section 4011 of ERISA, a provision which requires certain underfunded plans to provide a funding notice to participants and beneficiaries.

D. *Quarterly Benefit Statements by Defined Contribution and 403(b) Plans*. Beginning with the 2007 plan year, the PPA requires administrators of defined contribution plans (other than one-participant plans) and tax deferred annuities (403(b) plans) to provide a benefit statement to each participant at least quarterly if the participant has the right to direct the investment of assets in his or her account. Other participants must receive a benefit statement at least annually. In addition, a participant can make a written request for a benefit statement (limited to one request per year). The benefit statement must include the following information:

- The total value of benefits accrued;
- The value of each investment to which assets in the participant's account are allocated (including the value of investments in employer securities);
- The participant's vested accrued benefit or the earliest date on which the accrued benefit will become vested;
- Where relevant, an explanation of any permitted disparity or floor-offset arrangement that may apply in determining accrued benefits under the plan;
- An explanation of any limits or restrictions on the participant's right to direct investments;
- An explanation of the importance of a well-balanced, diversified portfolio;
- A statement of the risk of holding more than 20% of a portfolio in the securities of a single entity; and
- A notice directing the participant to the Department of Labor's website for information on investing and diversification.

E. *Defined Benefit Plan Statements*. For plan years after December 31, 2006, defined benefit plans are required to furnish benefit statements once every three years. Alternatively, the plan could furnish an annual notice of the availability of statements to vested participants or provide benefit statements on written request (limited to one request per year). Defined benefit plan statements must include information regarding accrued and vested benefits, and the earliest date on which any nonvested benefits will become vested. The statements must also include explanations of any permitted disparity as well as the effect of any floor-offset arrangement.

F. *Field Assistance Bulletin 2006-03*. On December 20, 2006, the Department of Labor's Employee Benefits Security Administration issued Field Assistance Bulletin ("FAB") 2006-03. This FAB provides general guidance regarding new participant notice requirements in

the Pension Protection Act of 2006. These changes are effective for plan years beginning after December 3, 2006.

As discussed above, PPA Section 508(a) made a number of significant changes to ERISA's participant notice requirements. The most important change is an affirmative obligation to automatically furnish benefits statements. Plans with individual accounts that allow participant directions of investments must provide a benefit statement at least once per quarter. Other individual account plans must provide a benefit statement at least once a year. Defined benefit plans must provide a statement at least once every three years. Plans are also required to increase the information contained in benefit statements. In addition, the PPA requires DOL to provide model benefit statements by August 1, 2007.

According to the FAB, these requirements have generated considerable concern among plan administrators, service providers, and others. In response, the FAB states that the DOL will treat plan administrator as satisfying the Section 105 notice requirements "…if the plan administrator has acted in good faith with a reasonable interpretation of those requirements." The FAB then addresses several questions regarding those requirements.

First, the FAB states that pending DOL guidance, good faith compliance "does not preclude the use of multiple documents or sources for benefit statement information." The FAB adds an important provision: recipients must be given an explanation of how and when the required information will be furnished. This explanation must be written in a manner that the average participant can understand and provided before the date the plan must provide its first enhance benefit statement.

Second, the new statute permits the use of electronic or other means to provide the required information, and the DOL has a "safe harbor" regulation regarding electronic communications. FAB notes that the Treasury and the IRS recently issued their own safe harbor regulation regarding use of electronic media. Pending its review of this regulation, the DOL will consider benefit statements issued in accordance with the Treasury regulation as good faith compliance with the new notice requirements.

Third, the FAB addresses the timing of the benefit statements. For plans with participant-directed investments, a calendar year plan would have to provide a statement for the quarter ending March 31, 2007. If the plan does not have participant direction, the first statement for a calendar year would cover the 2007 plan year. A statement furnished within 45 days of the end of either the calendar quarter or plan year, as applicable, will "constitute good faith compliance." For defined benefit plans, the first required statement would cover the 2009 plan year.

Fourth, the FAB states that a participant loan provision does not mean that participants have the right to direct investments of their accounts.

Fifth, for now, benefit statements must describe limitations on participant investment direction imposed by the plan, but not limitations imposed by "investment funds, other investment vehicle or by state or federal securities laws."

Sixth, the FAB includes model language regarding the importance of a well-balanced diversified portfolio.

Seventh, the FAB discusses good faith compliance with the PPA provision requiring a plan to diversify investments in employer securities.

Finally, the FAB includes a web site address regarding how to comply with a new PPA requirement. The address is: http://www.dol.gov/ebsa/investing.html.

G. *Form 5500 Changes*. For plan years beginning on or after January 1, 2007, the PPA eliminates the Form 5500 reporting requirement for one-person plans with fewer than $250,000 in assets. It also requires the Departments of Labor and Treasury to implement simplified reporting for plans with fewer than 25 participants.

In July 2006, the Department of Labor together with the IRS and the PBGC proposed significant changes to the Form 5500 and its related schedules. These proposals were supplemented by additional proposed regulations issued on December 11, 2006, designed to incorporate PPA requirements. The combined proposals include the following changes:

- A new short Form 5500 filing that would be available to plans covering fewer than 100 participants that are invested exclusively in easy-to-value investments, such as mutual funds. The December proposal indicates that this Form is to serve as the simplified report required by the PPA for plans with fewer than 25 participants;

- All service providers receiving fees in excess of $5,000 would be required to be listed, rather than only the 40 receiving the most compensation;

- Plan service providers receiving compensation from third parties in excess of $1,000 in connection with plan services would be required to indicate that fact. This would apparently require disclosure of the amount of such compensation received by service providers who receive 12b-1 and other fees with respect to plan investments; and

- Schedule B, relating to actuarial information, would be replaced by separate forms for single employer and multiemployer plans. The new schedules will include actuarial worksheets designed to allow the government agencies to evaluate a plan's compliance with the PPA's funding requirements. The new rules are proposed to be effective for 2008 plan year filings.

H. *Electronic Display of Form 5500*. For plan years beginning after 2007, the PPA requires the Form 5500 annual report to be filed electronically, thereby allowing the Department of Labor to comply with a new mandate to post the Form on its website. If a plan sponsor or administrator maintains an intranet website, it must post the Form on its intranet.

V. FIDUCIARY RESPONSIBILITY

A. *Mapping Allowed*. The PPA addresses the long-standing concern of fiduciary responsibility when a plan changes investment providers and a participant's investment in a mutual fund or other investment fund offered by the replaced provider is automatically transferred or "mapped" into a corresponding fund offered by the new provider. The Department of Labor has long warned that fiduciaries may not have any protection under Section 404(c) of ERISA for losses experienced in the new fund. The PPA makes Section 404(c) relief available as long as the fund into which the account is "mapped" has characteristics that are reasonably similar to the fund previously selected by the participant, and the participant does not instruct the plan fiduciary not to proceed with the mapping transaction. This relief, which will apply to plan years beginning after December 31, 2007, is conditioned on providing notice of the change at least 30 days and no more than 60 days before its effective date.

B. *Blackout Notice to One Person Plans*. The Sarbanes-Oxley Act added a blackout notice requirement when participants are not allowed to direct plan investments, obtain plan loans, or receive distributions from a plan for a period of time. Effective retroactively to the date the blackout notice rules first took effect, the PPA provides that the blackout notice requirement does not apply to one-person and partner-only plans.

C. *Plan Asset Rules*. The PPA modifies the Department of Labor's plan asset regulation which provides that, if a plan covered by ERISA or Code Section 4975 acquires an equity interest that is not publicly traded in an investment fund other than a registered mutual fund, the fund's underlying assets are treated as plan assets subject to the fiduciary provisions of ERISA and/or Code Section 4975 unless "benefit plan investors" hold less than 25% of each class of equity interest in the entity. The PPA provides that plans not subject to ERISA (e.g., governmental plans, foreign plans and non-electing church plans) are not to be treated as "benefit plan investors" and are not to count toward the 25% limitation.

The PPA also provides that an entity that is treated as holding plan assets is deemed to do so only in proportion to the equity held by the benefit plan investors. For example, if the underlying assets of Fund A are treated as plan assets because 30% of its equity is held by benefit plan investors, and Fund A acquires $1,000,000 of an equity class of securities in Fund B, only $300,000 of the equity securities held by Fund A is treated as being held by benefit plan investors and counted toward the 25% limitation in determining whether Fund B's underlying assets are treated as plan assets.

The changes to the plan asset rules are effective on August 17, 2006.

Comment: It is anticipated that the changes to the plan asset rules will allow non-publicly traded investment funds to accept more ERISA plan money.

D. *New Prohibited Transaction Exemptions*. Effective for transactions occurring after August 17, 2006, the PPA creates new statutory prohibited transaction exemptions to permit certain recurring transactions, such as block trading, cross trading, foreign exchange transactions and the purchase or sale of securities by means of an electronic communications network.

Transactions between a plan and a service provider who has no discretionary authority or control regarding plan investments are also permitted as a statutory exemption, provided that certain notice requirements are met. An additional statutory exemption would apply to securities and commodities transactions that are otherwise prohibited if the transaction is corrected promptly following discovery that it is a prohibited transaction.

E. *Annuities in Defined Contribution Plans*. The PPA directs the Department of Labor to issue final regulations by August 17, 2007, clarifying that the selection of an annuity contract as an optional form of distribution from an individual account plan is not subject to the "safest available annuity" standard stated in an earlier Department release. The selection of an annuity is to be governed by applicable fiduciary standards, such as prudence.

VI. MASSACHUSETTS HEALTH CARE LAW

A. Introduction. In April 2006, Massachusetts enacted legislation requiring most state residents to carry health insurance either through their employers or individually. Employers that fail to provide health insurance to their employees may be subject to a surcharge of $295 annually per employee plus additional penalties. The new law imposes several obligations on employers, even if they are already offering health insurance coverage to their employees.

This legislation, which is administered by the Division of Health Care Finance and Policy (the "Division"), imposes multiple requirements on employers. The five most significant obligations are:

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

B. Employer Obligations.

- *Premium Conversion Plan*. By July 1, 2007, all employers doing business in Massachusetts must adopt and maintain a premium conversion (also known as a Code Section 125 or cafeteria) plan that allows employees to pay their share of health care premiums with pre-tax dollars. Such premium conversion plans must also allow employees who obtain health care through the Commonwealth's newly-created Health Insurance Connector Plan (the "Connector") to pay their Connector premiums with pre-tax contributions. Employers will be required to file a copy of their premium conversion plans with the Commonwealth when regulations are issued.

Comment: Most premium conversion plans will need to be amended to comply with the Connector requirement to allow employees to pay their Connector premiums with pre-tax dollars. The Wagner Law Group would be happy to assist in this regard.

• *Employer HIRD Forms*. Effective July, 1, 2007, employers with more than 10 employees doing business in Massachusetts will be required to file information about the health coverage they provide to their employees on an Employer HIRD Form to be made available by the Division. Emergency regulations implementing this requirement were issued on January 1, 2007 and have since been repealed due to changes in the law. New proposed regulations should be issued shortly. The emergency regulations described below, however, do provide insight regarding the information employers may be required to file. The emergency regulations would have required employers to file the following information each year:

- Employer's legal name, employer's d/b/a name, federal employer identification number and Division of Unemployment Assistance account number;
- Number of full-time employees (includes seasonal and temporary employees, but not independent contractors);
- Number of part-time employees (includes seasonal and temporary employees, but not independent contractors);
- Whether the employer offers subsidized health insurance to full-time employees;
- Whether the employer offers subsidized health insurance to part-time employees; and
- Whether the employer has filed its premium conversion plan with the Commonwealth.

Employers should consider taking steps to determine how to capture required information. Furthermore, employers should consider designating a responsible individual authorized to verify and certify the accuracy of the information submitted in the Employer HIRD Form.

The Division will conduct data matches with the Division of Unemployment Assistance and the Department of Revenue to verify the accuracy of the information filed on Employer HIRD Forms. Emergency regulations would have imposed a penalty of not less than $1,000 and not more than $5,000 on employers that knowingly falsify or fail to file required information.

New employers may be required to register with the Division when they register with the Division of Unemployment Assistance.

The emergency regulations stated that an employer has more than 10 employees if the sum of the total payroll hours for all employees for the period October 1 through September 30 divided by 1,820 is greater than 10. Payroll hours included regular hours, vacation, sick, FMLA leave, short-term disability, long-term disability, overtime and holiday hours. As a result, employers may not be able to simply count the number of employees to determine if they exceed the 10-employee threshold.

- *Employee HIRD Forms*. Emergency regulations also would have required each Massachusetts employer who files an Employer HIRD Form to also collect a signed Employee HIRD Form from each employee who **declines**:

    - employer-sponsored health coverage;

    - employer-arranged health coverage (i.e., through the Connector plan with pre-tax dollars); or

    - participation in the employer's premium conversion plan.

Employers would have been required to obtain signed Employee HIRD Forms within 15 days after the close of the open enrollment period for the employer's health insurance, or if earlier, July 1 of the reporting year. New hires would have been required to sign the Employee HIRD Form within 15 days of their date of hire. If an employee failed to return the signed Form, the employer would have needed to document diligent efforts to obtain the signed Employee HIRD Form and maintain the documentation for three years.

Employers would have been required to maintain signed Employee HIRD Forms for at least three years and make them available to the Division upon request. Employers that knowingly falsify required information would have been subject to a penalty of not less than $1,000 and not more than $5,000.

- *Employer's Fair Share Contribution*. 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 must cover under its health insurance plan at least 25% of its employees employed at Massachusetts locations who work at least 35 hours per week, whether or not they are Massachusetts residents for the period from October 1 through September 30 of each year.

    - *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 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.

Comment: It appears that the 33% test only applies for the year ending September 30, 2007. Therefore, all employers may be required to demonstrate compliance with the 25% test for years ending after that date. Employers who pass using the 33% test as of September 30, 2007, may need to modify their programs to ensure compliance with the 25% test for later years.

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.

- *Free Rider Surcharge*. Effective July 1, 2007, in addition to the Fair Share Contribution, an employer with more than 10 employees that does not provide the required health care, or 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. Final regulations, issued on December 22, 2006, have recently been repealed due to changes in the law. However, the repealed regulations do provide some insight regarding how the Division will implement the Free Rider Surcharge. In accordance with the repealed regulations, the surcharge ranged from 10% to 55% of the Commonwealth's costs for these services. However, the first $50,000 of health care provided to the employer's employees would have been exempt from the surcharge. The surcharge would have been based on services provided after June 30, 2007.

In accordance with the repealed regulations, each employer would have been 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.

- *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.

C. Individual Obligations.

The law requires all residents of the Commonwealth to have health insurance, 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. These individuals and groups may be combined by the Connector in an effort to reduce costs.

Individuals may receive a subsidy for heath insurance coverage. Those who are under the federal poverty level will receive health coverage at no cost, while those who earn up to

300% of the poverty level will have subsidized coverage. For 2007, 300% of the federal poverty rate is approximately $29,400 for an individual and $60,000 for a family of four.

On their 2007 state income tax returns, individuals will have to affirm that they have health insurance coverage. Those that do not have health insurance can lose their state personal income tax exemption. If uninsured in subsequent years, penalties will be assessed based on the cost of individual coverage.

D. Insurers' Obligations.

- *Nondiscrimination Rule*. Effective July 1, 2007, a group health insurance policy or contract (including HMOs but excluding stand-alone dental plan arrangements) cannot be issued in Massachusetts if the employer contributes a smaller percentage of the insurance premium for one employee than for another employee who receives an equal or greater salary. To date, Massachusetts has not issued any regulations or guidance on how this provision should be interpreted. This nondiscrimination rule does not apply to self-insured group health plans.

  Comment: It is important to remember that this provision is directed at the insurance companies, and it is the insurers, and not employers, that are responsible for compliance. In fact, ERISA is likely to preempt (invalidate) any attempt to apply this rule directly to employers.

- *Dependent Coverage*. Effective January 1, 2007, group health insurance policies and contracts (but not self-insured plans) 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. Presumably, 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. There does not appear to be any requirement that the employer continue to make contributions for dependents who are no longer covered under the plan. Thus, the former dependent child may have to pay the entire cost of coverage. The new Massachusetts dependent coverage requirement is in addition to and independent of the COBRA continuation coverage requirement.

E. Conclusion.

The new health care law was written in an effort to extend health coverage to the majority of Massachusetts residents. There are many questions that remain to be answered. The law imposes several new obligations on employers. It also imposes penalties on individuals who, while having incomes above the poverty level, simply do not have the means to pay for mandatory insurance.

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.

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