830 CMR 111M.00: INDIVIDUAL HEALTH COVERAGE

Section

111M.2.1: Health Insurance Individual Mandate; Personal Income Tax Return Requirements

(1) Statement of Purpose; Application and Effective Date; Organization.

(a) The goal of the Massachusetts Health Care Reform Act (St. 2006, c. 58), is to ensure that virtually all Massachusetts residents have affordable, comprehensive health insurance designated as "creditable coverage."

Under St. 2006, c. 58, a resident is required to indicate whether he or she has health insurance on his or her Massachusetts personal income tax return. A resident who has access to affordable coverage but who does not obtain the coverage, and to whom an exception does not apply, is subject to penalties under M.G.L. c. 111M, § 2 which will be imposed through the individual's personal income tax return. 830 CMR 111M.2.1 explains various aspects of the health insurance individual mandate, including the need to declare health insurance coverage on the income tax return, exceptions to the mandate, calculation of any applicable penalties, employer reporting responsibilities under M.G.L. c. 62C, § 8B, and appeal rights of taxpayers in connection with the penalty under M.G.L. c. 111M, § 2.

St. 2006, c. 58 creates a new independent authority, the Commonwealth Health Insurance Connector Authority, which is responsible, among other things, for setting standards to determine whether affordable health insurance is available to residents, based on the percentage of income available to obtain coverage and the price of coverage. The Connector is also responsible for reviewing appeals of the health care individual mandate due to hardship.

In general, the implementation of the health care law involves multiple agencies including the Connector and the Department of Revenue. The purpose of 830 CMR 111M.2.1 is to explain the role of the Department in implementing St. 2006, c. 58. 830 CMR 111M.2.1 must be read in conjunction with any pertinent regulations promulgated by the Connector or other applicable agencies.

For tax years beginning on or after January 1, 2014, the federal Affordable Care Act instituted a federal mandate on individuals to obtain and maintain health insurance. While both Massachusetts and federal health care reform include this individual responsibility requirement, the details associated with the respective mandates differ. Specifically, there are differences associated with the penalties imposed on those who are not exempt from the federal mandate and fail to comply with the mandate requirement, with the standards defining what constitutes affordable coverage, and with the standards defining the type of health insurance that satisfies the coverage requirement.

With respect to penalties, to ensure that no taxpayer is subject to the aggregation of both the state and federal penalties, this regulation provides an adjustment in the circumstance where an individual is subject to both the federal and the Massachusetts penalties.

(b) Effective beginning with taxable year 2007, 830 CMR 111M.2.1 applies to the penalty imposed under M.G.L. c. 111M, § 2. Effective January 1, 2008, 830 CMR 111M.2.1 applies to the penalty imposed under M.G.L. c. 62C, § 8B. *See* St. 2006, c. 58.

(c) 830 CMR 111M.2.1, is organized as follows:

1. Statement of Purpose; Application and Effective Date; Organization
2. Definitions
3. Individual Mandate for Health Insurance Coverage
4. Massachusetts Personal Income Tax Return; Requirements Relating to Health Insurance Coverage
5. Penalty for Failure to Obtain Affordable Health Insurance Coverage; Interaction with the Federal Affordable Care Act
6. Exceptions to the Individual Mandate for Health Insurance Coverage
7. Appeals; Abatement of Penalty for Failure to Obtain Affordable Health Insurance
8. Employers and Other Persons Required to Document Health Insurance Coverage
9. Penalty for Failure to Provide Documentation of Health Insurance

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(2) Definitions.

Affordability Schedule, annual schedule of affordability adopted by the Board pursuant to 956 CMR 6.05: *Determining Affordability* that shows the amount of money, based on an individual's adjusted gross income, that the individual can be expected to contribute toward the cost of health insurance that meets minimum creditable coverage standards.

Board, the Board of the Commonwealth Health Insurance Connector Authority, established by M.G.L. c. 176Q, § 2.

Creditable Coverage, as defined in M.G. L. c. 111M, § 1 and 956 CMR 5.03: *Minimum Creditable Coverage*.

Commissioner, the Commissioner of the Department of Revenue.

Connector, the Commonwealth Health Insurance Connector Authority established pursuant to M.G.L. c. 176Q.

Department (DOR), the Department of Revenue.

Lapse in Coverage, in the case of an individual who loses creditable coverage due to job loss or otherwise, the period that elapses before the individual regains creditable coverage.

Penalty, unless the context requires otherwise, the penalty imposed by M.G.L. c. 111M, § 2, for failure to obtain health insurance meeting standards for minimum creditable coverage.

Resident for Health Care Purposes, an individual as defined under M.G.L. c. 111M, § 1 "Resident"(3) or (13).

Resident for Personal Income Tax Purposes, an individual as defined under M.G.L. c. 62, § 1(f).

(3) Individual Mandate for Health Insurance Coverage.

(a) Beginning July 1, 2007, the following individuals 18 years of age and older are required by M.G.L. c. 111M, § 2(a) to obtain and maintain health insurance designated as creditable coverage if such coverage is deemed affordable to them under schedules set annually by the Board:

1. residents of the Commonwealth, and
2. individuals who become residents of the Commonwealth, within 63 days of becoming a resident.

In tax years 2008 and thereafter, residents who have terminated any prior creditable coverage are required to re-obtain creditable coverage within 63 days of such termination.

(b) Creditable Coverage. The Connector will define the parameters regarding what constitutes creditable coverage. The minimum requirements for policies to qualify as creditable coverage may vary from year to year, as determined by the Connector. *See* 956 CMR 5.03: *Minimum Creditable Coverage*.

(c) Applicability of Mandate: Affordability. An individual is required to obtain and maintain health insurance only if affordable coverage is determined to be available to that individual. The Connector is responsible for setting annual Affordability and Premium Schedules related to coverage. Generally, the determination is based on the premium amount that is deemed affordable based on an individual's adjusted gross income. The Department will follow the determinations of affordability as determined by the Connector. The Department will not make determinations of affordability separate from the Connector.

(d) The health care individual mandate does not give individuals the alternative of self-insurance.

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(4) Massachusetts Personal Income Tax Return; Requirements Relating to Health Insurance Coverage.

(a) Residents Required to Report Health Insurance Coverage on Personal Income Tax Return. A resident who files or is required to file a Massachusetts personal income tax return is required to indicate on the return whether he or she had creditable coverage in force during the taxable year, as described in 830 CMR 111M.2.1(4)(a)1. and 2., to document such coverage. Coverage may be individual coverage or coverage as a named beneficiary of a policy covering multiple individuals. Generally, this documentation will be accomplished by providing information furnished to the resident on Form MA 1099-HC, as discussed in 830 CMR 111M.2.1(8). If the coverage requirement cannot be demonstrated and coverage is deemed affordable for the taxpayer, the taxpayer will be assessed the penalty at M.G.L. c. 111M, § 2, unless an exception applies (as described in 830 CMR 111M.2.1(6)).

1. Taxable Year 2007. Every person who files or is required to file an individual return as a resident, either separately or jointly with a spouse, and every part-year resident who establishes a Massachusetts domicile more than 63 days before the end of the taxable year must indicate on the return whether such person or persons, as of December 31, 2007, had creditable coverage in force.

2. Taxable Years Beginning on or after January 1, 2008. Every person who files or is required to file an individual income tax return as a resident, either separately or jointly with a spouse, and every part-year resident who resides in the Commonwealth for more than 63 days, must indicate on the return whether such person or persons had creditable coverage in force for each of the 12 months of the taxable year for which the return is filed.

(b) Schedule HC, Health Care Information. In general, taxpayers are required to provide health insurance information to the Commissioner by completing Schedule HC, Health Care Information, as part of their personal income tax returns. Taxpayers who have required coverage will so indicate and will be required to provide information documenting such coverage. In most cases, the information necessary to document coverage will have been provided to the taxpayer by the taxpayer's insurer or employer on Form MA 1099-HC (as described in 830 CMR 111M.2.1(8)).

In the case of a taxpayer who does not have creditable coverage, the taxpayer will determine by completing Schedule HC whether coverage is deemed affordable for the particular individual (as described in 830 CMR 111M.2.1(3)(c)) such that the mandate applies. The instructions to Schedule HC include affordability and premium tables showing the monthly premium amount that a taxpayer is deemed to be able to afford. Based on these tables, a taxpayer who does not have coverage will determine whether affordable health insurance is deemed to be available and therefore whether the mandate applies to that taxpayer.

If the mandate does apply, based on deemed affordability, the taxpayer may claim various exceptions (as described in 830 CMR 111M.2.1(6)) on Schedule HC. Claims for the hardship exception to the mandate should be indicated by completion of Schedule HC-A, Health Care Appeals. In the case where coverage is deemed to be affordable to the taxpayer and no exception applies, the applicable penalty (as described in 830 CMR 111M.2.1(5)) is determined on Schedule HC.

(5) Penalty for Failure to Obtain Affordable Health Insurance Coverage; Interaction with the Federal Affordable Care Act.

(a) Penalty; In General. In general, a resident who has access to affordable health insurance coverage but does not obtain and maintain the coverage may be subject to a penalty under M.G.L. c. 111M, § 2, which will be imposed through the resident's personal income tax return. If the coverage requirement cannot be demonstrated and no exception applies, the taxpayer will be assessed the penalty as further provided in 830 CMR 111M.2.1(5).

Except as provided in 830 CMR 111M.2.1, the penalty will be assessed and collected in the manner of a tax under M.G.L. c. 62C. An appeal on any issue connected with the assessment of the penalty other than hardship will be filed with the Department. However, (as described in 830 CMR 111M.2.1(6) and (7)) all appeals of assessments or proposed assessments of a penalty on the basis of claimed hardship are within the jurisdiction of the Connector and are subject to such procedures as may be established by the Connector. To the extent of any inconsistency or overlap between processes established by M.G.L. c. 62C and those established by the Connector, the Connector's procedures will supersede those of M.G.L. c. 62C.

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(b) Penalty; Taxable Year 2007.

1. Assessment on the Return. If a taxpayer does not indicate on his or her return whether the taxpayer maintained health insurance, or if the taxpayer indicates that he or she did not have creditable coverage in force on December 31, 2007, then the taxpayer shall self-assess or be assessed the penalty of the loss of the personal exemption at M.G.L. c. 62, § 3B(b), or, in the case of a taxpayer who files jointly with a spouse who did maintain coverage, the loss of ½ of the personal exemption. However, the penalty will not be triggered by a lapse in coverage of 63 days or less in a case where the lapse period encompasses December 31, 2007.

2. Assessment by the Commissioner. If a taxpayer indicates that he or she had creditable coverage in force on December 31, 2007, but the Commissioner determines after the fact, based on the information available to him, that the requirement was not met, then the Commissioner will assess the penalty of the loss of the personal exemption at M.G.L. c. 62, § 3B(b), or, in the case of a taxpayer who files jointly with a spouse who did maintain coverage, the loss of ½ of the personal exemption, first giving notice to such person of his intent to do so and an opportunity for an appeal. However, the penalty will not be triggered by a lapse in coverage of 63 days or less in a case where lapse period encompasses December 31, 2007.

(c) Penalty; Taxable Years Beginning on or after January 1, 2008.

1. Assessment on the Return. If a taxpayer does not indicate on his or her return whether the taxpayer maintained health insurance, or if the taxpayer indicates that he or she did not have creditable coverage in force, then a penalty will be assessed of up to 50% of the cost of the lowest cost premium available to the individual through the Connector. The penalty will be assessed for each of the months the individual did not meet the requirement of creditable coverage. However, the penalty will not be triggered by a lapse in coverage of 63 days or less between periods of coverage. In the case of an individual with a lapse in coverage exceeding 63 days, the penalty will be assessed for the period in excess of 63 days.

2. Assessment by the Commissioner. If the taxpayer indicates that he or she had health insurance which meets the creditable coverage standards in force, but the Commissioner determines after the fact, based on the information available to him, that the requirement of creditable coverage was not met, then the Commissioner will assess the penalty first giving notice to such person of his intent to do so and an opportunity for an appeal. The penalty is an amount up to 50% of the cost of the lowest cost premium available to the individual through the Connector. The penalty will be assessed for each of the months the individual did not meet the requirement of creditable coverage. However, the penalty will not be triggered by a lapse in coverage of 63 days or less. In the case of an individual with a lapse in coverage exceeding 63 days, the penalty will be assessed for the period in excess of 63 days.

3. Determination of Penalty Amount. The Commissioner will annually publish a penalty schedule. The penalty calculation will be based on the lowest monthly cost premium available through the Connector in the taxable year to which the penalty applies.

(d) Interest and Penalties under M.G.L. c. 62C, §§ 32 through 33. Interest and penalties under M.G.L. c. 62C, §§ 32 through 33 accrue on unpaid penalties under M.G.L. c. 111M, § 2 in the same manner as they apply to unpaid taxes. Interest on the penalty under M.G.L. c. 111M, § 2 commences with the due date of the original return without regard to extensions and continues to the date of the payment of the penalty.

(e) Enforcement . The Commissioner shall have all enforcement and collection procedures available under M.G.L. c. 62C to collect any penalties assessed under 830 CMR 111M.2.1(5)(e). However, no penalties will be enforced against an individual seeking review until the review is complete and any subsequent appeals are exhausted.

(f) Commonwealth Care Trust Fund. The Commissioner shall deposit all penalties assessed under M.G.L. c. 111M. § 2 that he or she collects into the Commonwealth Care Trust Fund.

(g) Interaction with the Federal Affordable Care Act.

1. Background. The Affordable Care Act is the Patient Protection and Affordable Care Act, Public Law 111-148, and the Health Care and Education Reconciliation Act, Public Law 111-152, as amended.

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In general, under the Affordable Care Act, for each month during the taxable year, a nonexempt individual must have minimum essential coverage or pay the shared responsibility payment. An individual has minimum essential coverage for a month in which the individual is enrolled in and entitled to receive benefits under a program or plan identified as minimum essential coverage in U.S. Treas. Reg. § 1.5000A-2 for at least one day in the month.

A taxpayer is liable for the shared responsibility payment for a month under the provisions of U.S. Treas. Reg. § 1.5000A-1(c). For each taxable year, the shared responsibility payment of an individual is computed under U.S. Treas. Reg. § 1.5000A-4.

For federal income tax purposes, an individual is exempt from liability for the shared responsibility payment for a month under the provisions of U.S. Treas. Reg. § 1.5000A-3.

2. Adjustment For Payment of the Federal Shared Responsibility Payment. For months beginning after December 31, 2013, the federal Affordable Care Act requires that for each month of the taxable year, a nonexempt individual must have minimum essential coverage or pay a shared responsibility payment. A taxpayer's liability for the shared responsibility payment for a month must be reported on the taxpayer's federal income tax return for the taxable year that includes any months of noncompliance.

For tax years beginning on or after January 1, 2014, an individual who does not have health insurance meeting both the Massachusetts standard of creditable coverage and the federal standard of minimum essential coverage may be subject to both (1) the Massachusetts penalty imposed by M.G.L. c. 111M, § 2, and (2) the federal shared responsibility payment under IRC § 5000A. However, in the circumstance where a taxpayer is subject to both the Massachusetts penalty and the federal shared responsibility payment, the amount of the taxpayer's Massachusetts penalty is reduced to account for payment of a federal shared responsibility payment. If the federal shared responsibility payment is greater than the amount that the taxpayer would owe as the Massachusetts penalty, the Massachusetts penalty is reduced to zero.

Example. In 2014, taxpayer J failed to obtain and maintain health insurance for all 12 months. As a result, J is subject to both a federal shared responsibility payment of $95 and a Massachusetts penalty (before adjustment) of $708. After adjustment for the amount of J's liability for the federal shared responsibility payment of $95, the amount of J's Massachusetts penalty for 2014 is $613 ($708 - $95).

3. In a case where a taxpayer has not actually paid the federal shared responsibility payment for the taxable year, the Commissioner has the authority to disallow the adjustment to the Massachusetts penalty provided above in 830 CMR 111M.2.1(5)(g)2.

4. Special Rules. The Commissioner will issue additional guidance to address the interaction of the federal shared responsibility payment and the Massachusetts penalty in special circumstances. To the extent that federal law may be amended to defer or eliminate a federal shared responsibility payment, the provisions of 830 CMR 111M.2.1 pertaining to the calculation and imposition of a Massachusetts penalty remain in effect, and adjustment of the Massachusetts penalty amount to take into account the impact of the federal shared responsibility payment would not be necessary.

(6) Exceptions to the Individual Mandate for Health Insurance Coverage. Residents to whom the individual mandate applies who have not purchased health insurance satisfying the requirement of creditable coverage will not be subject to penalty if one or more of the following exceptions apply. A taxpayer should indicate on Schedule HC whether an exception is being claimed.

(a) Connector Certificate of Exemption (Issued in Advance of Tax Filing). By regulation, the Connector has established procedures for granting an annual certificate upon the request of a resident who:

1. will be filing a Massachusetts personal income tax return;
2. has sought to purchase health insurance coverage through the Connector; and
3. seeks a certificate stating that no Connector health plans are affordable for such person. *See* 956 CMR 6.06: *Determining Affordability for the Individual Mandate*. A taxpayer who has received a Certificate of Exemption from the Connector should so indicate on the taxpayer's Schedule HC and must provide the certificate number provided by the Connector.

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(b) Exemption from Coverage Requirement Based upon Religious Belief.

1. General. An individual will generally be exempt from the penalty under M.G.L. c. 111M, § 2 if he or she files a sworn affidavit with his or her personal income tax return stating that he or she did not have creditable coverage and that his or her sincerely held religious beliefs are the basis of the refusal to obtain and maintain creditable coverage during the 12 months of the taxable year for which the return was filed. Claiming the religious exemption on Schedule HC along with the signature of the taxpayer on his or her personal income tax return fulfills the affidavit requirement.

2. Scope of Exemption. No Meaningful Benefit from Coverage. The individual health care mandate in Massachusetts is a requirement to maintain health insurance coverage. The Department interprets the religious exemption as a legislative acknowledgement that maintenance of health insurance would provide little benefit to an individual whose sincerely held religious beliefs would cause the individual to object to *substantially all* forms of treatment that would be covered by the insurance. It is appropriate for the religious exemption from the individual mandate to be available to such a person. On the other hand, health insurance may provide a substantial benefit to an individual who would object to certain specific treatments, such as blood transfusions, but who would otherwise seek standard medical treatment of conditions such as a broken bone or an infection. Thus, a claim of religious exemption in the latter situation would not be appropriate.

Sincerely held religious beliefs, including the scope of objections to various potential health care treatments, will vary among individuals. Thus, whether health insurance would provide *no meaningful benefit* to an individual, such that a claim of religious exemption from the individual mandate would be appropriate, is a matter of individual conscience. However, the Department may question a claim of exemption where facts are sufficiently extreme as to cast doubt on the sincerity of the religious beliefs asserted.

3. Medical Health Care. Any individual who claimed a religious exemption from the individual mandate but received medical health care during the taxable year for which the return is filed shall be liable for providing or arranging for full payment for the medical health care *and* be subject to the penalty assessed under M.G.L. c. 111M, § 2. For purposes of 830 CMR 111M.2.1(5)(b)3., the Department will interpret "medical health care" as health treatment by or supervised by a medical doctor and customarily covered by health insurance policies qualifying as minimum creditable coverage. Medical health care includes, without limitation, acute care treatment at hospital emergency rooms, walk-in clinics, or similar facilities. Medical health care excludes treatment not administered or supervised by a medical doctor, such as chiropractic treatment, preventive dental care, midwifery, personal care assistance, and eye examinations in situations not customarily covered by basic health insurance policies. Medical health care will also exclude physical examinations where required by third parties, such as a prospective employer, and vaccinations.

4. Self-insurance Is Not an Alternative to the Individual Mandate. The health care individual mandate does not give individuals the alternative of self-insurance. Where maintenance of health insurance would provide meaningful benefit to an individual, taking that individual's religious beliefs into account, separate payment by the taxpayer or others for medical health care services does not remove the statutory requirement for insurance coverage or the penalty for failure to obtain required coverage.

(c) Hardship (as Determined by the Connector). Schedule HC includes a set of worksheets and schedules to determine if health insurance is deemed affordable for a taxpayer. If these worksheets and schedules indicate that a taxpayer could have afforded health insurance such that a penalty for lack of coverage would normally apply, the taxpayer may nevertheless appeal imposition of the penalty by filing an appeal claiming that a hardship prevented him or her from purchasing health insurance. Hardship appeals may be requested on the income tax return by completion and filing of Schedule HC-A. The determination of whether to allow an appeal is made by the Connector, not the Department. If a taxpayer files with his or her income tax return a Schedule HC-A requesting a hardship appeal, the Department will not assess a penalty unless a final determination is received from the Connector denying the appeal. Procedural issues relating to hardship appeals are discussed in greater detail in 830 CMR 111M.2.1(7): *Appeals.*

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(7) Appeals; Abatement of Penalty for Failure to Obtain Affordable Health Insurance.

(a) General; Applicable Appeals Procedures; Coordination with Connector. The penalty is generally assessed and collected in the manner of a personal income tax under M.G.L. c. 62C. Accordingly, abatement and appeal processes under M.G.L. c. 62C generally apply where a taxpayer wishes to apply for an abatement of a penalty that has previously been assessed or where a taxpayer wishes to contest the Commissioner's proposal to assess such penalty. The major exception to the applicability of M.G.L. c. 62C processes is that hardship appeals of the penalty are reviewed by the Connector, not the Department, with a right to seek judicial review pursuant to M.G.L. c. 30A, § 14, instead of appealing to the Appellate Tax Board. Hardship appeals are subject to the procedures of the Connector, and such procedures supersede M.G.L. c. 62C. *See generally*, 956 CMR 6.00: *Determining Affordability for the Individual Mandate*. Actions for judicial review of an appeal decision are subject to the provisions of M.G.L. c. 30A, § 14, and any standing orders of the Superior Court regarding such actions. A primary condition of Connector procedures for hardship claims is that appeals of a penalty may be filed only once for a particular tax year. If a taxpayer files Schedule HC-A with the taxpayer's income tax return requesting a hardship appeal, the appeal may be pursued only at that time; it may not be raised again later on an application for abatement under M.G.L. c. 62C, § 37.

(b) Hardship Appeal to the Connector.

1. Hardship Appeal Requested on Original Return; Penalty is Not Assessed Pending Appeal.

a. A taxpayer who files Schedule HC-A, Health Care Appeal, as part of his or her personal income tax return is not required to assess the penalty at M.G.L. c. 111M, § 2 when computing the amount of tax due. Rather, such a taxpayer is allowed to compute and pay the tax due separate from the penalty pending the determination by the Connector of whether the taxpayer has grounds for appeal of the penalty.

b. The procedure for filing a hardship appeal and the grounds for appeal are explained in the Connector's regulations. *See* 956 CMR 6.07: *Hardship Appeals* and 6.08: *Grounds for Appeal of Penalty*.

c. A taxpayer who files Schedule HC-A requesting a hardship appeal will be sent a Notice, "Statement of Grounds for the Appeal of the Health Insurance Mandate" or any successor Notice. The Notice will inform the taxpayer of such application and documentation requirements as may be determined by the Connector. The Notice will also inform the taxpayer of the Commissioner's intent to assess the applicable penalty if the appeal is dismissed or denied on the merits by the Connector. It is anticipated, subject to inter-agency agreements, that the taxpayer will be instructed to submit the appeal request form, along with any documentation and further information to the Department for processing purposes. The Department will forward the application, documentation and further information to the Connector for consideration and for determination on the merits.

d. The Connector will inform the Commissioner of its determination of a hardship appeal. If the appeal is denied, the Commissioner will assess the penalty. In the event that the taxpayer seeks judicial review of an appeal denial by the Connector, the Department will not assess the penalty unless and until the determination of the Connector is finally upheld.

2. Hardship Appeal Not Requested on Original Return.

a. Application for Abatement. In cases where a taxpayer does not file Schedule HC-A with the personal income tax return requesting a hardship appeal, the penalty, if otherwise applicable, will be self-assessed and collected. In this situation, the taxpayer may later claim hardship by timely filing the request in the manner of an application for abatement under M.G.L. c. 62C, § 37. The Commissioner will refer the claim to the Connector in a manner similar to the process followed when Schedule HC-A is filed with the original return. If the Connector grants the appeal, the Commissioner will abate the penalty. Any appeal from a denial by the Connector must be timely taken to Superior Court. If the Connector informs the Commissioner that an appeal has been denied, the individual is not a person aggrieved by the failure of the Commissioner to abate a tax for purposes of M.G.L. c. 62C, § 39 and no appeal of the hardship determination lies with the Appellate Tax Board.

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b. Stay of Involuntary Collection. The filing of an application for abatement shall stay involuntary collection of the disputed penalty. Interest under M.G.L. c. 62C, § 33(a) will continue to accrue. The stay expires on the date on which any right of appeal from a refusal or deemed refusal by the Commissioner to grant an abatement of such penalty expires without any appeal having been filed, or as otherwise provided in M.G.L. c. 62C, § 32(e).

c. No Penalty Self-assessed on Original Return. In an instance where a taxpayer indicated on the taxpayer's personal income tax return that the taxpayer carried required health insurance or that the individual mandate did not apply due to reasons other than hardship, and the Department later determines that a penalty should be due because health insurance was not in fact maintained or because the individual mandate did apply under the circumstances, the Department will send the taxpayer a Notice of Intent to Assess the applicable penalty amount. The taxpayer may confer with the Commissioner in the same manner as upon receipt of a Notice of Intent to Assess a tax and may dispute the proposed assessment, provided however that a hardship appeal will be determined by the Connector in the manner described in 830 CMR 111M.2.1(7)(b)2.a.

(c) Other Appeals – Penalty Is Assessed Prior to Appeal. Appeals based on issues other than hardship are governed by M.G.L. c. 62C, §§ 26, 37.

Example: In the course of preparing Schedule HC, Health Care, and filing his personal income tax return for 2007, a taxpayer made a mistake in applying the Affordability Tables. Based upon his mistaken understanding of the Affordability Tables, this taxpayer indicated on Schedule HC that private health insurance *was deemed affordable* to him and, as a result, that he was not entitled to his personal exemption. The taxpayer did not claim a hardship appeal to the Connector. After filing his return without the benefit of his personal exemption and paying his tax (including the penalty assessed under M.G.L. c. 111M, § 2), the taxpayer subsequently learned that the correct application of the Affordability Tables to his situation would have shown that private health insurance *was not deemed affordable to him,* and that he was entitled to his personal exemption. This taxpayer may file an application for abatement within the time limits provided in M.G.L. c. 62C, § 37.

Example: A taxpayer filed a hardship appeal along with his Massachusetts personal income tax return for 2007. The taxpayer received the Department's Notice, Statement of Grounds for the Appeal of the Health Insurance Mandate. The Notice explained that failure to respond to the Notice within 30 days would result in the automatic dismissal of the appeal. The taxpayer failed to respond to the Notice, resulting in the denial of his appeal. The taxpayer did not seek judicial review of the dismissal in Superior Court. Accordingly, the penalty under M.G.L. c. 111M, § 2 was assessed and billed. For tax year 2007, this taxpayer is not entitled to file an application for abatement of the penalty based on hardship because a taxpayer is entitled to file only one hardship appeal to challenge the imposition of a penalty for a particular tax year. *See* 956 CMR 6.07; 830 CMR 111M.2.1(7)(a).

(8) Employers and Other Persons Required to Document Health Insurance Coverage.

(a) Documentation of Creditable Health Care Coverage; Health Plan That Is Employment-sponsored. Effective Jan 1, 2008, an employer or other sponsor of an employment-sponsored health plan is required to:

1. provide, or arrange with service providers or insurance carriers to provide, a written statement (Form MA 1099-HC), annually on or before January 31st of each year, to each subscriber or covered individual residing in the Commonwealth to whom it provided creditable coverage, as defined in M.G.L. c. 111M, in the previous calendar year; and
2. provide a separate report electronically verifying the statement to the Commissioner.

The first statements and reports are required to be issued no later than January 31, 2008 for the tax year ending December 31, 2007.

(b) Documentation of Creditable Health Care Coverage; Health Plan That Is Not Employment-sponsored. If a resident is not covered under a Massachusetts-based employment-sponsored health plan, carriers licensed or otherwise authorized to offer health coverage under M.G.L. chs. 175, 176A, 176B, and 176G shall:

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1. provide, or arrange with service providers to provide, a written statement (Form MA 1099-HC), annually on or before January 31st of each year, to each subscriber or covered individual residing in the Commonwealth to whom it provided creditable coverage, as defined in M.G.L. c. 111M, in the previous calendar year; and
2. provide a separate report electronically verifying the statement to the Commissioner.

In *lieu* of Form MA 1099-HC, individuals who are recipients of MassHealth and ConnectorCare will be provided the information needed to indicate their coverage on Schedule HC. For these individuals, MassHealth will provide an annual report to the Department to document the coverage of both MassHealth and ConnectorCare recipients.

(c) Content of Reports. The statements and reports shall identify the carrier or employer, the covered individual and covered dependents, the insurance policy or similar numbers and the dates of coverage during the year, and shall provide other information as required by the Commissioner of Revenue; but shall be limited to the minimum amount of personal information necessary for the purpose of M.G.L. c. 111M and shall not include information about previous or current diagnoses or treatments. Except for the office of Medicaid, the statements and reports shall not include social security numbers. The Commissioner of Revenue, in consultation with the Commissioner of Insurance, may specify the content and format of the statements and reports. The Commissioner of Revenue may disclose the information in the statements and reports to the Division of Insurance, the Division of Health Care Finance and Policy and the Connector. M.G.L. c. 62C, § 8B(c). The information in the statements and reports shall be confidential and shall not constitute a public record.

(9) Penalty for Failure to Provide Documentation of Health Insurance.

(a) Pursuant to M.G.L. c. 62C, § 8B, carriers, employers or other sponsors of employment-sponsored health plans that fail to provide written statements to covered individuals or to report to the Commissioner in violation of 830 CMR 111M.2.1(9) shall be punishable by a penalty of $50 per individual to which the failure relates, not to exceed $50,000 per year per violator.

(b) The Commissioner shall assess the penalties under M.G.L. c. 62C, § 8B as a tax subject to M.G.L. c. 62C.

(c) The Commissioner may abate for reasonable cause all or any portion of the penalties imposed under M.G.L. c. 62C, § 8B. A taxpayer seeking an abatement of any penalties must present specific facts establishing that its failure to submit the documentation or reports required by M.G.L. c. 62C, § 8B was due to reasonable cause. A mere assertion, by affidavit or otherwise, that a taxpayer's failure to timely file such documentation or reports was reasonable or excusable due to oversight or inadvertence is insufficient to establish reasonable cause.

REGULATORY AUTHORITY

830 CMR 111M.2.1: M.G.L. c. 62C, §§ 3 and 8B and c. 111M, § 5.