Commonwealth of Massachusetts
Group Insurance Commission

805 CMR 9 Proposed Amendments

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MA Group Insurance Commission

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Background

Chapter 28 of the Acts of 2023

SECTION 83. Notwithstanding any general or special law to the contrary, the group insurance commission, in consultation with the comptroller and the executive office for administration and finance, shall offer health insurance coverage to any new employee who is eligible for health insurance benefits. If any such employee opts to receive health insurance benefits provided by the group insurance commission, such health insurance coverage shall be effective as of the employee's start date if the employment start date falls on the first day of the month or as of the first day of the month following the employee's start date if the employment start date falls on any day other than the first day of the month.

Effective 7/1/2024

Amended Regulations

805 CMR 9.00: ELIGIBILTY AND PARTICIPATION

9.01(1) and (2) New Employees

9.01(3) Effective Date of Insurance Coverage

9.01(4)(c) Retroactive Health Insurance Effective Date

9.01(5) Employer Notification to New Employee

9.01(6) New Employees' Duty to Notify Employer

9.01(7) Payment

9.19 Reemployed Persons

9.22 Dental and Vision Benefits

9.23(2) Dependent Care Assistance Program

9.25 Appeals

9.26 Health Insurance Buy-out Option

9.27 Long-term Disability Insurance

9.01(1)
New Employees

- Removed 10-day decision period. This was tied to the process necessary to enroll employee under the 60-day period and allowed for the processing of paper forms.

- Added that if a new employee does not enroll when first eligible, they are presumed to have declined coverage.

(1) A new Employee's department or agency head shall determine ~~within the first ten days of employment~~ whether the Employee is eligible for Commission coverage. Employees whose duties are Seasonal or Emergency Employment or of a duration of not more than three months with no reasonable expectation of an extension, are not eligible for Commission coverage. Department or agency heads who are unable to determine eligibility shall send all information relating to the new Employee's work to the Commission for a final and binding eligibility determination. ~~Persons~~ Employees who do not enroll in Commission coverage when they are first eligible are presumed to have declined coverage and may later enroll during the Commission's Annual Enrollment or with a qualifying event as specified in the Commonwealth's Section 125 Cafeteria Plan. Once an Employee enrolls in a health plan, the next opportunity to change plans is the GIC's next Annual Enrollment period, except as otherwise required by law.

(2) Reserve. ~~Members of the Judiciary who qualify as Employees are eligible for Commission coverage~~.

9.01 (3)
Effective Date of Insurance Coverage

- All language reflecting the existing process and 60 day waiting period is struck.
- adjusted to reflect the new coverage effective period.
- added language emphasizing employee's responsibility to pay premiums for the period prior to when payroll deductions begin.
- coverage will terminate if premiums are not paid.

1.Effective Date of Insurance Coverage. Eligible New Employees who apply for ~~coverage~~ Commission Benefits within the new hire enrollment period ~~within ten days of the first day of employment~~ shall be insured on the first day of the month following ~~the earlier of 60 calendar days or two calendar months from~~ the employee's start date. If the ~~unless the~~ start date is the first of the month, the employee shall be insured on that day. ~~The first day of employment shall be counted when determining the effective date of Commission coverage, and one or more days of authorized leave of absence shall be counted as an equivalent number of days of employment~~.

The Commission benefits effective date as a new hire cannot be changed. Employees will be responsible for payment of premiums for elected benefits from the effective date of coverage until payroll deductions can be initiated. Failure to pay the premiums will result in termination of coverage.

9.01(4)(c)
Retroactive Health Insurance Effective Date

- fail-safe provision allowing for retroactive coverage in the case of a medical emergency or unplanned medical expenses prior to the start of coverage.

- struck language that related to when premiums are charged depending on what day an employee started.

(4)(c)….

Coverage shall become effective as of State or Municipal Employees' first day of active employment ~~or Municipal Employees' first day of the waiting period~~, subject to their timely payment of the full-cost health insurance premium for the entire hiatus period. ~~New Employees who begin employment on the 16th day of a month or later will not be charged premium for that month; new Employees who begin employment on or before the 15th day of a month shall be charged the full premium cost for the month.~~ Coverage entitles the Employee only to those benefits that are otherwise available through the health plan selected, and claims may be denied in whole or in part, consistent with the health plan's covered benefits.

Employees' effective date of life insurance, if eligible, shall only become effective as described in 805 CMR 9.01(3) or 9.02.

9.01(5)
Employer Notification to New Employee

Amended language to require employer to inform employee of the application deadline in order to begin coverage on first of month and that the employee will be initially billed for premium.

(5) The Employee's department or agency head or Group Insurance Coordinator shall inform newly hired employees of their eligibility for ~~whether they are eligible for~~ Commission coverage, ~~and what~~ the benefits that are available to them, and the application deadline. ~~including Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation coverage, and the application deadline.~~ The Group Insurance Coordinator shall also notify newly hired employees that premium deductions for Commission coverage are taken one month in advance of coverage or that the Employee will be billed for missed premiums. The Group Insurance Coordinator shall also provide information to the employee about Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation coverage.

9.01 (6)
New Employees' Duty to Notify Employer

Removed 10-day reference and added reference to using the Portal to enroll.

(6) New Employees' Duty to Notify Employer. Eligible Employees who are advised by their department or agency head that they are eligible for Commission coverage shall, ~~within ten days of beginning work or beginning the health care waiting period,~~ inform their employer whether they intend to enroll in Commission coverage. Those enrolling in Commission coverage shall promptly select coverage and complete all necessary forms or make coverage elections through the GIC Member Portal. Persons who fail to enroll in Commission coverage when first eligible may do so during the next ~~occurring~~ Annual Enrollment period ~~or with satisfactory proof of loss of other coverage~~ or with a qualifying event as specified in the Commonwealth's Section 125 Cafeteria Plan.

9.07
Subsequent Determination of Ineligibility

- Added language for new hires that notifies them they will be billed prior to start of deductions
- failure to pay will result in termination
- if terminated, can enroll during annual enrollment or qualifying event.

(7) Premium payment for Commission coverage must be made one month in advance of coverage in order for coverage to become effective. For new hires, employees may be billed for the period of coverage prior to the start of payroll deductions. Failure to pay the billed premiums will result in coverage termination. The employee can enroll during the next annual enrollment or with a qualifying event as specified in the Commonwealth's Section 125 Cafeteria Plan. ~~or applicable qualifying event.~~

9.19(3)
Reemployed Persons

- Added language stating that a Reemployed Person is responsible for ensuring their premium contribution is correct in instances where contribution percentages revert back to their original start date.

- The new language clarifies that the Commission will not reimburse the employee for erroneous contribution payments prior to alerting us of an error.

(3) Notwithstanding 805 CMR 9.19(2), Insured State Employees who terminate employment while in good premium payment standing and are rehired as State Employees in a position with benefits within two years of the date of termination of their employment shall be considered to have been hired on their original hire date for the purposes of computing the Commonwealth's share of their premiums. The employee is responsible for ensuring their premium contribution is correct based on their original hire date. The Commission will not reimburse premium differentials that occurred prior to notification to the Commission of an incorrect premium contribution.

9.22
Dental and Vision Benefits

Struck language that excluded the Trial Court from eligibility for these benefits.

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Certain State Employees who are not covered by collective bargaining are eligible for Dental and Vision benefits that are offered primarily to managers, legislators, legislative staff, and certain Executive Office staff. All Employees of higher education, ~~the Trial Court system~~, and authorities other than the Massachusetts Bay Transportation Authority are ineligible for Com- mission Dental and Vision coverage. Certain Massachusetts Bay Transportation Authority employees who are not covered by collective bargaining are eligible for Commission Dental and Vision coverage, as are certain confidential Employees. Employees may only change plans during Annual Enrollment, even if their dentist leaves the plan.

9.23 (2)
Dependent Care Assistance Program

Expanded the definition of dependent to align it with federal law on who may be covered under the plan.

(2) Dependent Care Assistance Program. Active State Employees who work at least 18.75 hours in a 37.5-hour work week or 20 hours in a 40-hour work week and are eligible for Health Coverage who have employment-related dependent care expenses for ~~Dependent~~ a dependent child~~dren~~ who is~~are~~ younger than 13 years old when care was provided and for whom a tax exemption can be claimed, a spouse who was physically or mentally unable to care for themselves and lived with you for more than half the year, a dependent who was physically or mentally unable to care for themselves and for who an exemption can be claimed, and lived with you for mor than half the year ~~or 13 years of age or older and are disabled dependents~~ may pay for certain dependent care expenses through the Commission's Dependent Care Assistance Program. Participants elect an annual dollar amount to be taken as a payroll deduction, up to a maximum set by the Commission, to pay for qualified child and elder day care, after school programs, and certain day camp dependent care expenses. Participants must reenroll each year during open enrollment.

9.25
Appeals

- Removed reference to appeals to Executive Director and the Commission Appeals Committee

- Benefit decision appeals were delegated to the organizations administering the plan and third party independent reviewers in compliance with the ACA.

(1) ~~Any person who is aggrieved by a decision of the Commission, or by a final decision of one of the Commission's self-insured plan administrators about benefits may appeal in writing to the Commission's Executive Director. Benefits that are explicitly excluded from coverage in the plan of benefits are not appealable. The Executive Director shall consult with the Commission's General Counsel to determine whether the matter warrants presentment to the Commission's Appeals Committee. If presentment is warranted, the Executive Director shall enter the matter on the Commission's Appeals Docket for resolution via the Commission's appeals procedures. The Appeals Committee's decisions are final and binding, and may only be reconsidered if new information that was unknowable at the time of the initial appeal to the Appeals Committee would alter the outcome of the appeal. Appellants may pend their appeals to the Commission up to a maximum of 120 days after their initial filing in order to obtain additional information. Appeals that exceed the 120-day period will be closed without prejudice to the appellant.~~

(2) ~~Notwithstanding 805 CMR 9.25(1), the Executive Director may modify appeals procedures~~ In order to achieve compliance with requirements of federal law including, but not limited to, 42 U.S.C. § 300gg-19~~. To that end, Commission's Executive Director may~~ the Commission delegates external appeals procedures to the Commission's self-insured plan administrators. ~~If the Executive Director has delegated appeals procedures to one or more plan administrators, a~~Any person who is aggrieved ~~by a decision of the Commission, or~~ by a final decision of one of the Commission's self-insured plan administrators about benefits, may appeal in writing to the plan administrator.

Contact Information