MASSACHUSETTS

Michael T. Caljouw
Vice President
State Government & Regulatory Affairs

August 14, 2015

Daniel R. Judson, Commissioner
Massachusetts Division of Insurance
1000 Washington Street, 8th floor
Boston, MA 02118-6200

Re: Regulatory review public comment session – **Health insurance regulations**

Dear Commissioner Judson:

Blue Cross and Blue Shield of Massachusetts (BCBSMA) provides the following comments pursuant to Executive Order 562 relative to the reduction of unnecessary regulatory burden. BCBSMA supports the collaborative dialogue that the Division of Insurance has conducted with stakeholders to root out regulatory burdens that are "confusing, unnecessary, inconsistent and redundant." This is a particularly important mission since there have been many changes in the Massachusetts and national health care environment which merit consideration. As you review stakeholder comments, we support your perspective that any changes should be in the best interest of health care members, purchasers and health plans.

Also, as we noted on August 7th, the FY16 budget signed by Governor Baker created important changes to the Center for Health Information and Analysis through the creation of an Oversight Council on which the Commissioner of Insurance will sit. As such, critical inter-agency communication among "health care" agencies is essential to the proper functioning of that entity and in furtherance of reducing unnecessary administrative burden. The newly created Oversight Council is a key opportunity for guiding principles supporting increased efficiency in data demands and production.

In addition to the oral comments provided on August 7th, we offer the following additional comments (see also Attachments 1 and 2):

211 CMR 41.00 – Nongroup Health Insurance Rate and Policy Form Filings, Review, and Hearing Procedures under M.G.L. c. 176M

- Suggested change: Repeal full regulation

- Rationale: M.G.L. c. 176M, which is the source of these regulations, is an obsolete statute. Chapter 176M regulated the nongroup market before it was merged with the small group market in 2006. When the small and nongroup markets were merged, the nongroup market became governed by M.G.L. c. 176J. As a result, BCBSMA, and to our knowledge every other carrier, no longer writes products under 176M.

T :: 617.246.3499 F :: 617.246.3824 F :: michael.caljouw@bcbsma.com

101 Huntington Avenue, Suite 1300 | Boston, MA 02199-7611 | www.bluecrossma.com

211 CMR 52.00 – Managed Care Consumer Protections and Accreditation of Carriers

- **Suggested change #1**:
  - Include "physician assistant" in definitions and throughout 211 CMR 52.00 (alongside "nurse practitioner").

Rationale:
  - Makes regulations consistent with current Massachusetts law.

- **Suggested change #2**: Amend section 52.12 – (Standards for Provider Contracts)
  - Add electronic notification as an option for providing notice (see Attachment 1)

Rationale:
  - Clarifies that notice may either be fulfilled electronically or in writing and makes regulations consistent with current business standards.

- **Suggested change #3**: Amend section 211 CMR 52.13 – (Evidences of Coverage)
  - Strike paper format requirement in recognition of the development of electronic EOCs (see Attachment 1)
  - Add "carrier" to involuntary disenrollment of members (see Attachment 1)

Rationale:
  - The requirement for paper EOCs is administratively burdensome and no longer consistent with current, common business practices.
  - "Carrier" should be added to this regulation since otherwise there would be unreasonable restrictions on the right to cancel or refuse to renew an insured's coverage for commission of acts of physical or verbal abuse against a carrier.

- **Suggested change #4**: Amend section 211 CMR 52.15 – Managed Care Consumer Protections (Provider Directories)
  - Strike paper directory requirement (see Attachment 1)

Rationale:
  - The requirement for paper directories is administratively burdensome and no longer consistent with current, common business practices. BCBSMA maintains electronic directories that are updated one time per week, whereas paper directories are updated only once per year.

211 CMR 63.00 – Young Adult Health Benefit Plans

- **Suggested change**: Repeal full regulation

Rationale:
  - These regulations have been replaced by 956 CMR 8.00 and, therefore, need to be repealed.

211 CMR 66.00 - Small Group Health Insurance [Suggested changes: see below for changes by subsection.

Suggested Changes to 211 CMR 66.04 – Definitions:

- Delete definition of "Actuarial Equivalent", as no longer applicable.
    - *Rationale*: This defined term is only used in the definition of "eligible individual" (and our recommendation below for revising the definition of eligible individual removes the language containing the term "actuarial equivalent") and certain subsections of 66.07 which we also recommend be deleted. This definition is not included in M.G.L. c. 176J, Sec. 1.
- Replace definition of "Creditable Coverage" with the attached new definition, to remove the last section referencing waiting periods and pre-existing conditions.
    - *Rationale*: This change would be consistent with the definition in M.G.L. c. 176J, Sec. 1. As further explained below, we recommend that references to waiting periods and pre-existing conditions be removed to be consistent with current law under c. 176J. See redlines on Attachment 2.
- Replace definition of "Eligible Dependent" with the attached new definition.
    - *Rationale*: This edit would make the regulation consistent with the current definition in M.G.L. c. 176J, Sec. 1 as updated by Chapter 35 of the Acts of 2013, Sec. 43 (176J updated effective 1/1/14 to include age limit of dependents). See redlines on Attachment 2.
- Replace definition of "Eligible Individual" with the attached new definition.
    - *Rationale*: This change make render the regulatory text consistent with the current definition in M.G.L. c. 176J, Sec. 1, as updated by Chapter 35 of the Acts of 2013, Sec. 44 (c. 176J was updated effective 1/1/14 to expand the definition of eligible individual to any individual who is a resident of the commonwealth). See redlines on Attachment 2.
- Delete definition of "Pre-existing Conditions Provision"
    - *Rationale*: This change is consistent with M.G.L. c. 176J, Sec. 1. The definition of "Pre-existing conditions provision" was deleted from c. 176J Sec. 1 on January 1, 2014 by Chapter 35 of the Acts of 2013, Sec. 46.
- Delete definition of "Waiting Period".
    - *Rationale*: This edit makes the regulation consistent with M.G.L. c. 176J, Sec. 1. The definition of "Waiting period" was deleted from c. 176J Sec. 1 on January 1, 2014 by Chapter 35 of the Acts of 2013, Sec. 47.

Suggested Changes to 211 CMR 66.05 – Minimum Coverage Standards:

- Update dates of open enrollment period listed in 211 CMR 66.05(1)(a) from July 1-August 15 to November 1-January 31. See redlines on Attachment 2.

    - *Rationale*: This would make DOI regulations consistent with current law requirements under M.G.L. c. 176J. Chapter 176J, sec. 4(a)(3) was updated by Chapter 3 of the Acts of 2013, Sec. 8, to revise the open enrollment period dates.

- Revise subsections 66.05(1)(a)(1)-(2) to reflect new requirements regarding enrollment of individuals. See redlines on Attachment 2.

    - *Rationale*: This change would provide consistency with legal requirements under M.G.L. c. 176J, Sec. 4(a)(2). Chapter 176J, Sec. 4(a)(2) was revised by Chapter 35 of Acts of 2013, Sec. 49 on January 1, 2014 (as well as Chapter 3 of Acts of 2013, Sec. 8, effective 2/15/13 and as reflected in DOI Bulletin 2013-04) to include certain individuals, other than just HIPAA-eligible individuals, in an exception to the mandatory open enrollment period.

- Revise effective dates of coverage listed in 66.05(1)(b) consistent with changes to M.G.L. c. 176J Sec. 4(a)(2) and 4(a)(3). See redlines on Attachment 2.

    - *Rationale*: This revision aligns effective dates of coverage with the current version of Chapter 176J, Secs. 4(a)(2) and (4)(a)(3) as updated by Chapter 35 of the Acts of 2013, Sec. 49 and Chapter 3 of the Acts of 2013, Sec. 8.

Suggested Changes to 211 CMR 66.07 -- Pre-existing Conditions and Waiting Periods:

- Delete subsections 66.07(3) - (9), leaving unchanged subsections (1) and (2) of 211 CMR 66.07. Also recommend adding one sentence prohibiting carriers from imposing pre-existing conditions or waiting periods on a health plan. See redlines on Attachment 2.

    - *Rationale*: These deletions and additions make the regulations consistent with M.G.L. c. 176J, Secs. 4 and 5. Chapter 35 of Acts of 2013, Sec. 50, deleted from 176J Sec. 5 the provisions regarding pre-existing conditions and waiting periods, and Chapter 35 of the Acts of 2013, Sec. 49, added a new sentence to c. 176J, Sec. 4(a)(2) prohibiting carriers from imposing pre-existing conditions or waiting periods of any duration. The sentence we recommend adding is identical to the language in c. 176J, Sec. 4(a)(2).

Suggested Changes to 211 CMR 66.09 -- Submission and Review of Rate Filings:

- Update filing deadlines listed in subsection 66.09(2) to July 1 for rates effective the following January 1. See redlines on Attachment 2.

    - *Rationale*: This reflects current submission deadlines set forth in M.G.L. c. 176J, Sec. 6(c). Chapter 176J Sec. 6(c) was updated by Chapter 35 of the Acts of 2013, Sec. 51, on July 5, 2013.

Suggested Changes to 211 CMR 66.12 -- Disclosure:

- Delete subsection (2). See redlines on Attachment 2.
    - *Rationale*: This deletion provides needed changes in light of current M.G.L. c.176J updated by the Acts of 2013 to remove references to pre-existing conditions and waiting periods.

Thank you for your consideration of these suggestions. We appreciate the opportunity for this dialogue. Please contact me if you have any questions at 617-246-3499.

Sincerely,

Michael T. Caljouw

Cc: Kevin Beagan, Division of Insurance
Rob Whitney, Division of Insurance

Attachment 1

211 CMR 52.12: Standards for Provider Contracts

(7) Contracts between carriers and health care providers shall state that the carrier shall notify providers either in writing or electronically of modifications in payments, modifications in covered services or modifications in a carrier's procedures, documents or requirements, including those associated with utilization review, quality management and improvement, credentialing and preventive health services, that have a substantial impact on the rights or responsibilities of the providers, and the effective date of the modifications. The notice shall be provided 60 days before the effective date of such modification unless such other date for notice is mutually agreed upon between the carrier and the provider.

211 CMR 52.13: Evidences of Coverage

(1) Evidences of Coverage as to a Carrier. A carrier shall, upon enrollment, ~~issue and deliver to at least one adult insured in each household residing in Massachusetts, upon enrollment:~~

~~(a) an evidence of coverage; or~~

~~(b)~~ refer at least one adult insured in each household residing in Massachusetts ~~the insured~~ to resources where the information described in such evidence of coverage can be accessed, including, but not limited to, an internet website. References to the terms, "internet website" shall include "intranet website" and "electronic mail" or "e-mail." An electronic evidence of coverage ~~in paper format~~ shall always be delivered to the group representative in the case of a group policy.

Formatted: Left, Indent: First line: 0"

(1)(b) refer the insured to resources where the information described in such evidence of coverage can be accessed, including, but not limited to, an internet website. References to the terms, "internet website" shall include "intranet website" and "electronic mail" or "e-mail." ~~An evidence of coverage in paper format shall always be delivered to the group representative in the case of a group policy.~~

(3)(i) The requirement that an insured's coverage may be canceled, or its renewal refused may arise only in the circumstances listed in 211 CMR 52.13(3)(i)1. through 5. 211 CMR 52.13(3)(i) shall apply to carriers, including dental and vision carriers.

1. failure by the insured or other responsible party to make payments required under the contract;
2. misrepresentation or fraud on the part of the insured;
3. commission of acts of physical or verbal abuse by the insured which pose a threat to providers, the carrier or other insureds of the carrier and which are unrelated to the physical or mental condition of the insured; provided, that the commissioner prescribes or approves the procedures for the implementation of the provisions of 211 CMR 52.13(3)(i)3.;
4. relocation of the insured outside the service area of the carrier; or
5. non-renewal or cancellation of the group contract through which the insured receives coverage;

(4)(a) The carrier has issued and delivered written notice to the insured that includes:

1. All necessary information and a clear explanation of the manner by which insureds can access their specific evidences of coverage and any amendments thereto through such internet website;
2. A list of the specific information to be furnished by the carrier through an internet website;
3. The significance of such information to the insured; and
~~4. The insured's right to receive, free of charge, a paper copy of evidences of coverage and any amendments thereto at any time;~~
~~5. The manner by which the insured can exercise the right to receive a paper copy at no cost to the insured; and~~
~~6~~4. A toll-free number for the insured to call with any questions or requests.

(b) ~~The carrier has taken reasonable measures to ensure that the information and documents furnished in an internet website is substantially the same as that contained in its paper documents.~~ All notice and time requirements applicable to evidences of coverage shall apply to information and documents furnished by an internet website.

~~(c) The carrier has taken reasonable measures to ensure that it furnishes, upon request of the insured, a paper copy of evidences of coverage and any amendments thereto.~~

211 CMR 52.15(1)(d): Provider Directories

(d) ~~If the carrier refers an insured to access provider directory information through an internet website, t~~The carrier must be able to demonstrate compliance with the following:

1. The carrier has issued and delivered written notice to the insured that includes:
   a. All necessary information and a clear explanation of the manner by which insureds can access their specific provider directory through an internet website;
   b. A list of the specific information to be furnished by the carrier through an internet website;
   c. The significance of such information to the insured; and
   ~~d. The insured's right to receive, free of charge, a paper copy of the provider directory at any time;~~
   ~~e. The manner by which the insured can exercise the right to receive a paper copy at no cost to the insured; and~~
   ~~f~~d. A toll-free number for the insured to call with any questions or requests.
2. ~~The carrier has taken reasonable measures to ensure that the information and documents furnished in an internet website is substantially the same as that contained in its paper documents.~~
3. All notice and time requirements applicable to evidences of coverage shall apply to information and documents made available by Internet. Information contained in the documents furnished in an internet website shall include the effective date and the published date of any updates, modifications or material changes.
4. The carrier updates the website as soon as practicable.
5. In the case of a group policy, the carrier delivers a ~~paper~~ copy of the provider directory to the group representative.

~~6. The carrier has taken reasonable measures to ensure that it furnishes, upon request of the insured, a paper copy of the provider directory.~~

(2) A carrier shall not be required to deliver a provider directory upon enrollment if a provider directory is delivered to the prospective or current insured, or in the case of a group policy, to the group representative, during applicable open enrollment periods.

~~(3) If delivering a paper copy of the provider directory, a carrier shall be deemed to have met the requirements of 211 CMR 52.15(1) if the carrier:~~
~~(a) provides to at least one adult insured in each household, or in the case of a group policy, to the group representative, at least once per calendar year an addendum, insert, or other update to the provider directory originally provided under 211 CMR 52.15(1); and~~
~~(b) updates its toll-free number within 48 hours and internet website as soon as practicable.~~

Attachment 2

Redlines to 211 CMR 66:

211 CMR 66.04:

Creditable Coverage: coverage of an individual under any of the following health plans with no lapse of coverage of more than 63 days:
(a) a group health plan;
(b) a health plan, including, but not limited to, a health plan issued, renewed or delivered within or without the commonwealth to an individual who is enrolled in a qualifying student health insurance program under M.G.L. c. 15A, § 18 or a qualifying student health program of another state;
(c) Part A or Part B of Title XVIII of the Social Security Act;
(d) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928;
(e) 10 U.S.C. 55;
(f) a medical care program of the Indian Health Service or of a tribal organization;
(g) a state health benefits risk pool;
(h) a health plan offered under 5 U.S.C. 89;
(i) a public health plan as defined in federal regulations authorized by the Public Health Service Act, section 2701(c)(I)(I), as amended by Public Law 104-191;
(j) a health benefit plan under the Peace Corps Act, 22 U.S.C. 2504(e);
(k) coverage for young adults as offered under M.G.L. c. 176J, § 10; or
(l) any other qualifying coverage required by the Health Insurance Portability and Accountability Act of 1996, as it is amended, or by regulations promulgated under that act.
~~211 CMR 66.04: Creditable Coverage applies to creditable coverage for portability as used in 211 CMR 66.00 in relation to any pre-existing condition provision or waiting period. It is not intended to define creditable coverage as it is defined by the Connector for purposes of determining individual responsibility for maintaining health coverage.~~

Eligible Dependent: the spouse or child of an eligible individual or eligible employee, subject to the applicable terms of the health benefit plan covering such individual or employee. The child of an eligible individual or eligible employee shall be considered an eligible dependent until the end of the child's twenty-sixth year of age.

Eligible Individual: an individual who is a resident of the commonwealth ~~and who is not seeking individual coverage to replace an employer-sponsored health plan for which the individual is eligible and which provides coverage that is at least actuarially equivalent to minimum creditable coverage as defined by Connector regulation 956 CMR 5.00. For the purposes of 211 CMR 66.00, continuation coverage under M.G.L. c. 176J, § 9 or under the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), shall not be considered an employer-sponsored health plan~~.

211 CMR 66.05:

66.05: Minimum Coverage Standards
(1) Offerings and Open Enrollment.
(a) Unless otherwise provided in 211 CMR 66.05, every carrier shall make available to every eligible individual and every eligible small business a certificate that evidences coverage for every health benefit plan that it provides to any other eligible individual or eligible small business whether issued or renewed to a trust, association or other entity that is not a group health plan, as well as to their eligible dependents. Every carrier must accept for enrollment any eligible individual or eligible small business that seeks to enroll in a health benefit plan provided, however, that a carrier shall only contract to sell a health benefit plan to an eligible individual or eligible dependent during the annual mandatory open enrollment period of November 1 to January 31~~July 1st to August 15th~~, except as follows:

1. A carrier shall enroll an eligible individual~~.~~ as defined in 211 CMR 66.04, and an eligible individual as defined in § 2741 of the Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. § 300gg-41(b) ~~("HIPAA-eligible individual")~~, into a health plan if such individual requests coverage within 63 days of termination of any prior creditable coverage.

2. A carrier shall enroll an eligible individual, as defined in 211 CMR 66.04, into a health plan if such individual requests coverage within 63 days of experiencing a qualifying event. A carrier shall enroll the eligible dependent(s) of an eligible individual into a health plan if coverage is sought for the eligible dependent(s) within 30 days of a qualifying event. For the purposes of 211 CMR 66.05(1)(a)2., qualifying events shall include, but not be limited to: marriage, birth or adoption of a child, court-ordered care of a child, or any other event as may be designated by the commissioner.

3. A carrier shall enroll an eligible individual who has been granted a waiver by the Office of Patient Protection.

(b) Coverage issued to eligible individuals under 211 CMR 66.05(1)(a) shall become effective on January 1 of the following year~~the first day of the month following receipt of a completed application~~, except for coverage issued pursuant to 211 CMR 66.05(1)(a)1. through 3. which shall become effective ~~within 30 days of the carrier's receipt of a completed application or approved waiver form~~ in accordance with the Patient Protection and Affordable Care Act, and any rules, regulations and guidances applicable thereto, as amended from time to time, subject to reasonable verification of eligibility. ~~For completed applications received in the last five days of a calendar month, carriers shall give eligible individuals the option of whether: 1. coverage will become effective as of the first day of the month following receipt of the completed application; or 2. coverage will become effective as of the first day of the second month following receipt of the completed application. Carriers shall notify applicants that opting to receive coverage effective the first day of the month following submission of a completed application may result in processing delays, including delays in the receipt of an identification card or entry into the carrier's enrollment system, if the carrier is unable to process the completed application by the first of the month.~~ Coverage issued to small businesses under 211 CMR 66.05(1)(a) shall become effective within 30 days of a carrier's receipt of a completed application. Any coverage issued pursuant to 211 CMR 66.05(1)(a)1. through 3. ~~to be effective in any month other than during the annual open enrollment period shall be for a~~

~~term of less than one year ending~~shall be in effect only through ~~July~~ December 31~~st~~ of the year of enrollment.

Formatted: Superscript

211 CMR 66.07:

66.07: Pre-existing Conditions and Waiting Periods.

(1) No carrier may exclude any eligible individual, eligible employee, or eligible dependent from a health benefit plan on the basis of age, occupation, actual or expected health condition, claims experience, duration of coverage, or medical condition.

(2) No carrier may modify the coverage of an eligible individual, eligible employee, or eligible dependent through riders or endorsements, or otherwise restrict or exclude coverage for certain diseases or medical conditions otherwise covered by the health benefit plan except as permitted under 211 CMR 66.00.

(3) A carrier shall not impose a pre-existing condition exclusion or waiting period of any duration on a health plan.

~~(3) No health benefit plan issued to eligible persons aged 19 and over, including eligible individuals, eligible employees, or eligible dependents, may include pre-existing condition provisions that exclude coverage for a period beyond six months following the eligible individual's, eligible employee's, or eligible dependent's date of enrollment. The pre-existing condition provision shall only relate to a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for such coverage and for which any medical advice, diagnosis, care or treatment was recommended or received during the six months before the eligible individual's, eligible employee's, or eligible dependent's date of enrollment. Pregnancy shall not be a pre-existing condition.~~

~~(4) No health benefit plan may include waiting periods that exclude coverage for a period beyond four months following the eligible individual's, eligible employee's, or eligible dependent's date of enrollment. Notwithstanding 211 CMR 66.07(4), no waiting period may be imposed if an eligible individual, eligible employee, or eligible dependent lacked creditable coverage for 18 months or more immediately prior to the date of enrollment.~~

~~(5) When a eligible individual or eligible small group changes from one health benefit plan to another, whether such health benefit plan is with the same carrier or a different carrier, the carrier may impose a new waiting period of not more than four months on the eligible individual or on all members of the eligible small group for only those services covered under the new health benefit plan that were not covered under the old health benefit plan.~~

~~(6) With respect to TA/HCTC-eligible persons, a carrier may not impose any pre-existing condition exclusion or waiting period following the TA/HCTC-eligible person's date of enrollment.~~

~~(7) In determining whether a pre-existing condition provision or waiting period applies to an eligible individual, eligible employee, or eligible dependent, all health benefit plans must credit the time the person was covered under prior creditable coverage if the prior creditable~~

~~coverage was continuous to a date not more than 63 days prior to the request for new coverage, exclusive of any applicable services waiting period under the new coverage, provided that the prior creditable coverage was reasonably actuarially equivalent to the new coverage. For the purpose of 211 CMR 66.07(6), "reasonably actuarially equivalent" means the following: (a) the Benefit Level Rate Adjustment factor for the new health benefit plan is no more than ten percentage points greater than the Benefit Level Rate Adjustment factor of the previous health benefit plan; provided, however, that if the Benefit Level Rate Adjustment factor for the new health benefit plan is more than ten percentage points greater than the Benefit Level Rate Adjustment factor of the previous health benefit plan, the eligible individual, eligible employee, or eligible dependent must receive at least the actuarially equivalent benefits of the previous health benefit plan during the term of the preexisting condition period or waiting period; or (b) if the previous coverage is under Medicare or Medicaid, or the individual seeking coverage is an eligible individual as defined in 211 CMR 66.05(1)(a)1., the previous coverage is presumed to be reasonably actuarially equivalent to the new health benefit plan. Notwithstanding 211 CMR 66.07(7), a carrier shall not impose on a HIPAA-eligible individual the requirement that said individual's prior creditable coverage be reasonably actuarially equivalent to that individual's new coverage.~~

~~(8) If a health benefit plan includes a waiting period, emergency services must be covered during the waiting period.~~

~~(9) A carrier may only impose either a pre-existing condition limitation or a waiting period; however no pre-existing condition limitation shall be imposed on an eligible person under age 19, including an eligible individual, eligible employee, or eligible dependent.~~

211 CMR 66.09:

(2) Submission of Rate Filings.
(a) Every carrier, as a condition of doing business under M.G.L. c. 176J and 211 CMR 66.00, must file electronically ~~all changes to~~ small group base premium rates and all changes to small group rating factors that are to be effective on January 1 of each year, on or before July 1 of the preceding year ~~electronically at least 90 days before their proposed effective dates~~. All base premium rates and rating factors are subject to disapproval if they do not meet the requirements of M.G.L. c. 176J.
(b) Small group rate filing materials submitted for review by the Division shall be deemed confidential and exempt from the definition of public records in M.G.L. c. 4, § 7, clause 26.

211 CMR 66.12:

66.12: Disclosure
Every carrier must make reasonable disclosure in plain English to prospective small business insureds and prospective individual insureds, as part of its solicitation and sales material, of:
(1) for a small group, the participation requirements or participation rate adjustments of the carrier with regard to each health benefit plan;
~~(2) permissible limits on pre-existing conditions and waiting periods;~~
(3) for a small group, exclusion or limitation of mandated benefits;
(4) mandatory offer and renewal provisions;
(5) rating limitations according to 211 CMR 66.08; and

(6) availability of health benefit plans only to employers if said health benefit plans are offered by the employer to all full-time employees who live in the commonwealth; provided, however, the employer shall not make a smaller health insurance premium contribution percentage amount to an employee than the employer makes to any other employee who receives an equal or greater total hourly or annual salary for each specific or general blanket policy of insurance for all employees.