Office of the Inspector General
Commonwealth of Massachusetts

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Ongoing Analysis of the Health Safety Net Trust Fund: The Religious Exemption from Mandated Health Insurance Coverage

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Executive Summary

Since 2004, the Legislature has directed the Office of the Inspector General ("Office") to study the Uncompensated Care Pool and the Health Safety Net program ("HSN"). This year, pursuant to its mandate under Section 160 of Chapter 38 of the Acts of 2013, the Office examined claims for reimbursement submitted to the HSN for health care services provided during calendar year 2012 to individuals who claimed the religious exemption to the requirement that all adult Massachusetts residents have health insurance. From the inception of this review, the Office has recognized that there are individuals who hold sincere religious beliefs that would cause them to decline substantially all forms of health care treatment; those individuals were not the subject of the Office's review.

To assist the Office's review, the HSN Office, which runs the HSN program, provided the Office with the names of individuals for whom health care providers submitted claims to the HSN for services provided in 2012. The HSN Office also worked with the Massachusetts Department of Revenue ("DOR") to provide the Office with the names of the taxpayers who filed for the religious exemption for calendar year 2012. The Office's comparison of the two lists yielded 401 individuals who both filed for the religious exemption and received health care services during calendar year 2012. The HSN paid providers $427,541.92 for these health care services.

The Office's review indicates that there are a number of individuals who are claiming the religious exemption even though they received health care treatment during the year for which they claimed the exemption, and even though they have a substantial history of participation in the health care system. This is contrary to both the intent and letter of the law, and the HSN should not be paying for health care for individuals who should be purchasing health insurance. This is also unfair to the Massachusetts residents who have obtained and maintained health insurance coverage, as well as to those who have paid the penalty for not having such coverage.

Based on these findings, the Office recommends that:

1. The DOR and the HSN Office should run annual data matches to determine whether taxpayers who claimed the religious exemption also received health care services paid for by the HSN. As a result of the Office's review, the HSN Office and the DOR recently conducted this match for calendar year 2012. Currently, the DOR is in the process of analyzing its next steps with regard to that group of taxpayers.

2. The DOR and MassHealth, the Massachusetts Medicaid program, should explore conducting an annual data match to determine whether taxpayers claiming the religious exemption are enrolled in MassHealth.

3. The DOR should work with the Center for Health Information and Analysis ("CHIA") to determine whether private health insurers are paying for medical care for taxpayers claiming the religious exemption. CHIA maintains an all-payer claims database that could be instrumental to such a data match. Performing this match will

allow the DOR, which has collected $119 million since 2008 from individuals who did not maintain mandated health insurance, to enforce the health insurance requirement equitably by ensuring that individuals who claim the religious exemption are complying with the applicable statutes and regulations.

4. The HSN Office should work with its partners to determine whether any alternate health care coverage exists for the individuals who are both filing for the exemption and receiving health care treatment to ensure that the HSN is truly the payor of last resort in Massachusetts.

5. The DOR should consider clarifying its instructions and form relating to the religious exemption to ensure that taxpayers are not erroneously claiming the exemption. The DOR has expressed its willingness to consider making revisions to its documents.

Introduction

I. The Office of the Inspector General

Created in 1981, the Office of the Inspector General ("Office") was the first state inspector general's office in the country. The Office's mission is to prevent and detect fraud, waste, and abuse in the expenditure of public funds. The Office investigates allegations of fraud, waste, and abuse at all levels of government; conducts programmatic reviews to identify systemic vulnerabilities and opportunities for improvement; and provides assistance to the public and private sectors to help prevent fraud, waste, and abuse in government spending. The Office also offers a wide range of training programs designed to promote excellence in public procurement and to enhance public purchasing officials' ability to operate effectively.

The Office has considerable experience reviewing health care programs and has issued a number of analyses, reports, and recommendations regarding Medicaid oversight, the Health Safety Net program ("HSN"), health care reform, and other health care topics. The Office also has expertise in developing fraud-control best practices for state agencies and municipalities.

Since 2004, the Legislature has mandated that the Office review the payment practices of the Uncompensated Care Pool ("Pool") – now known as the HSN Trust Fund. The HSN Trust Fund provides funds for the HSN program, a health care program that reimburses hospitals and community health centers for (1) treatment that they provide to uninsured and underinsured patients; and (2) bad debt. In the General Appropriation Act for Fiscal Year 2014, the Legislature directed the Office to study and review hospital practices paid for by the HSN Trust Fund:

> Notwithstanding any general or special law to the contrary, in hospital fiscal year 2014, the office of the inspector general may continue to expend funds from the Health Safety Net Trust Fund, established in section 66 of chapter 118E of the General Laws:
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> . . . .
>
> (2) for costs associated with maintaining a pool audit unit within the office; provided that the unit shall continue to oversee and examine the practices in all hospitals including, but not limited to, the care of the uninsured and the resulting free charges; provided further that the inspector general shall submit a report to the house and senate committees on ways and means on the results of the audits and any other completed analyses not later than March 1, 2014; and provided further, that for the purposes of these audits, allowable free care services shall be defined under said chapter 118E and any regulations adopted pursuant to that chapter.

2013 Acts ch. 38, § 160 ("Section 160").

II. The Health Safety Net

In 1985, the Legislature established the Pool as a financing mechanism to distribute the cost of providing free care more equitably among acute care hospitals. The creation of the Pool was intended to help pay for the costs of providing care to the uninsured and underinsured and to eliminate financial disincentives that a hospital might have to providing such care. The Pool helped to ensure that certain types of providers received some compensation for providing access to health care services for patients who had no other source of health care coverage.

In 2006, the Legislature created the HSN Trust Fund to replace the Pool. The HSN reimburses acute care hospitals and community health centers for allowable services provided to eligible, low-income uninsured and underinsured patients.[1] To be eligible for the HSN, patients must complete an application and satisfy various HSN requirements, including those relating to income and residency. The HSN also reimburses acute care hospitals and community health centers for "bad debt," meaning the costs of providing health care services to patients who fail to pay the facility. Bad debt recovery is not related to a patient's income, residency, or any other eligibility criteria, but providers must document their efforts to collect unpaid amounts before submitting a claim to the HSN. Payments from the HSN cannot exceed its funding for a given year, and if the HSN Office ("HSNO") anticipates that its payments will exceed its funding, it reduces the amount of payments to providers.

The HSN is not insurance and it does not pay for the cost of services provided by independent groups such as private physicians and specialty care groups. The HSN is the payor of last resort in Massachusetts and will not pay for any health care services that are covered by private insurance, Medicare, or Medicaid.

In 2012, the Legislature transferred the responsibility for overseeing the HSN from the Division of Health Care Finance and Policy ("DHCFP") to the Executive Office of Health and Human Services ("EOHHS"), which also has oversight of MassHealth, the Massachusetts Medicaid program. Within EOHHS, the HSNO is responsible for the administration of the HSN. In conjunction with the transfer of responsibility, DHCFP stopped collecting HSN claims as of May 1, 2012. After that, providers began submitting medical claims through the Medicaid Management Information System ("MMIS"), which is the MassHealth claims management system. MMIS and the HSNO review HSN claims for administrative and eligibility issues, and the HSNO completes the financial processing of the claims. Providers submit HSN dental claims directly to the HSNO for eligibility and financial processing. Currently, HSN eligibility information and the majority of HSN claim information from mid-2012 forward reside in MMIS and the MassHealth electronic data storage system ("Data Warehouse"), which also contains MassHealth claim information.

[1] Allowable services at hospitals include, but are not limited to, inpatient admissions, emergency services, primary care, day surgery, radiology, substance abuse treatment, and other enumerated services. Allowable services at community health centers include, but are not limited to, behavioral health services, cardiovascular and pulmonary diagnostic services, individual medical visits, and pharmacy services.

The Massachusetts Health Care Reform Law

In 2006, the Legislature passed Chapter 58 of the Acts of 2006, *An Act Providing Access to Affordable, Quality, Accountable Health Care* ("Health Care Reform law"). The Health Care Reform law was designed to ensure that virtually all Massachusetts residents have affordable, comprehensive health insurance. To that end, since July 1, 2007, the Health Care Reform law has required that individuals over 18 years old who are residents of the Commonwealth, or who become residents of the Commonwealth, obtain health insurance coverage. The Health Care Reform law refers to this mandatory health insurance as "creditable coverage."[2]

The Massachusetts Department of Revenue ("DOR") is responsible for monitoring and enforcing compliance with the creditable coverage provision of the Health Care Reform law. In keeping with this responsibility, the DOR created the Schedule HC Health Care Information form ("Schedule HC"), which Massachusetts taxpayers must complete and file along with their individual income tax returns. Every person who files or is required to file an individual income tax return must indicate on Schedule HC whether he had minimum creditable coverage for the past calendar year. A copy of the 2012 Schedule HC and the 2012 Massachusetts Schedule HC Health Care Special Section on Minimum Creditable Coverage ("2012 Line by Line Instructions") are attached as Appendix 1.

The 2012 Line by Line Instructions described "minimum creditable coverage" as insurance that, among other things, provided for a comprehensive set of services (*e.g.*, doctor visits, hospital admissions, day surgery, emergency services, mental health treatment, substance abuse services, and prescription drug coverage), doctor visits for preventative care without a deductible, and a cap on annual deductibles and out-of-pocket spending. In 2012, a person automatically met the mandatory health insurance requirement if he was enrolled in Medicare Part A or B, any Commonwealth Care or Commonwealth Care Bridge plan, any Commonwealth Choice plan, or MassHealth, among other plans.[3]

In the alternative, a taxpayer can indicate on Schedule HC that he is claiming an exemption from the mandatory health insurance requirement. Exemptions are available based on the lack of an affordable health plan, hardship, and religious belief. The DOR may impose a penalty on individuals who do not have mandatory health insurance and do not qualify for an exemption.[4] For 2012, the penalties ranged from $19 to $105 per month, depending on income level, age, and family size. Since the inception of the Health Care Reform law, the DOR has collected approximately $119 million in penalties against individuals who failed to obtain the requisite mandatory health insurance.[5] The DOR deposits penalties collected pursuant to this provision in the Commonwealth Care Trust Fund, from which the Secretary of Administration and Finance

[2] This report refers to "creditable coverage" as "mandatory health insurance" unless the context requires otherwise.

[3] The Massachusetts Health Insurance Connector Authority, the independent state agency that helps Massachusetts residents find health insurance coverage, created the regulatory definition of "creditable coverage."

[4] Taxpayers whose income is at or below 150% of the federal poverty level are not subject to the penalty.

[5] This does not include penalties imposed against individuals for improperly claiming the religious exemption. To date, the DOR has not collected any such penalties.

may transfer funds to the HSN Trust Fund as necessary to provide payments to hospitals and community health centers for reimbursable health services.

I. Exemption for a "Sincerely Held Religious Belief"

With regard to the religious belief exemption, an individual will generally be exempt from obtaining health insurance coverage if he files a sworn affidavit with his personal income tax return stating that: (a) he did not have mandatory health insurance; and (b) his sincerely held religious beliefs are the basis of the refusal to obtain and maintain mandatory health insurance during the taxable year for which he filed the return. Claiming the religious exemption on Schedule HC, along with the taxpayer's signature on the personal income tax return, satisfies this requirement.

The DOR has provided guidance regarding what constitutes a "sincerely held religious belief" for purposes of the religious exemption:

> 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.

830 CMR 111M.2.1(6)(b)(2) (emphasis in original). Since 2008, between 5,000 and 8,000 individual taxpayers have filed for the religious exemption each year:

Calendar Year	Taxpayers listed on Schedule HC	Filed for Religious Exemption	Percentage of taxpayers filing for religious exemption
2008	4,413,532	5,145	0.12%
2009	4,751,485	5,909	0.12%
2010	4,786,953	7,303	0.15%
2011	4,854,550	8,155	0.17%
2012	4,846,292	7,155	0.15%

Table 1: Taxpayers filing for the religious exemption[6]

II. Penalty for Claiming the Religious Exemption but Receiving Medical Health Care

There is a unique statutory penalty for individuals who claim the religious exemption from obtaining and maintaining mandatory health insurance but who receive health care, which the DOR refers to as Medical Health Care:

> For purposes of this provision, 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 by a medical doctor, such as chiropractic treatment, preventive dental care, mid-wifery, 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.

830 CMR 111M.2.1(6)(b)(3). If an individual who files for the religious exemption from the individual mandate receives Medical Health Care during the taxable year for which he filed the return, he must repay the full cost of the Medical Health Care *and* is subject to the DOR penalty for the failure to obtain mandatory health insurance. G.L. c. 111M, § 3. The applicable statute requires the DOR to collect these costs and penalties and to deposit them in the Commonwealth Care Trust Fund.

III. 2012 Schedule HC and the Religious Exemption

The 2012 Line by Line Instructions explained to taxpayers that:

> A religious exemption is available for anyone who has a sincere religious belief that is the basis of refusal to obtain and maintain health insurance coverage. Fill

[6] The number of taxpayers listed on Schedule HCs is higher than the number of tax returns filed for a particular year because taxpayers file Schedules HC listing either one or two taxpayers, depending on their filing status (married filing jointly, single, married filing separately, or head of household).

in the Yes oval(s) if you are claiming a religious exemption from the requirement to purchase health insurance based on your sincerely held religious beliefs.

The 2012 Schedule HC itself inquired: "Are you claiming an exemption from the requirement to purchase health insurance based on your sincerely held religious beliefs?" If so, the Schedule HC then directed a taxpayer intending to file for the religious exemption to indicate whether he received Medical Health Care during 2012. If the answer was "Yes," the Schedule HC required the taxpayer to answer additional questions regarding the availability of mandatory health insurance, whether such coverage was affordable, and whether the taxpayer was eligible for government-subsidized health insurance.[7] Based on the taxpayer's responses to these questions, he may or may not have been subject to the penalty for not having mandatory health insurance.

IV. The HSN and the Religious Exemption

In conjunction with the transfer of responsibility for overseeing the HSN from DHCFP to EOHHS, the Legislature provided that the DOR may disclose information to EOHHS to determine if a taxpayer who claimed the religious exemption received health services for which the HSN Trust Fund reimbursed a provider. G.L. c. 62C, § 21(b)(23). The previous iteration of this statute provided that the DOR could share information with DHCFP to determine if a taxpayer who claimed a religious exemption received health services for which the HSN Trust Fund reimbursed a provider.

[7] None of the individuals discussed in this report answered this question in the affirmative.

Analysis of the HSN and the Religious Exemption for Calendar Year 2012

As part of its HSN oversight responsibilities set forth in Section 160, the Office compared the list of the 282,200 individuals for whom health care providers filed valid claims with the HSN for calendar year 2012 with the list of 7,155 Massachusetts taxpayers who filed for the religious exemption for calendar year 2012. The Office identified 401 individuals who appeared on both lists (the "Matched Group"). In other words, 401 of the taxpayers who filed for the religious exemption in 2012 – or 5.6% of those taxpayers – received health care for which a provider submitted a valid claim for reimbursement from the HSN.[8]

From the beginning of this review, the Office has been keenly aware of and respects the fact that there are individuals who hold sincere religious beliefs which would cause them to decline substantially all forms of treatment that a physician would provide or supervise, and which health insurance would ordinarily cover. For those individuals, a claim of religious exemption from the individual mandate is consistent with the applicable statutes and regulations. Those individuals are not the subject of this report.

However, as described below, the Matched Group received many forms of health care treatment in 2012, much of which appears to fall within the DOR's definition of Medical Health Care. In addition to receiving health care services in 2012, many individuals in the Matched Group also have a history of eligibility for the HSN or enrollment in a publically-funded health care program, and of receiving health care paid for by those programs. This history is inconsistent with the premise underlying the religious exemption: that sincerely held religious beliefs preclude an individual from receiving substantially all forms of health care treatment such that health insurance would provide no meaningful benefit to that individual. In addition, the vast majority of the members of the Matched Group were under 50 years old. The demographics of the Matched Group, combined with their history of eligibility for or enrollment in publicly-funded health care programs and their receipt of health care treatment, raises the question as to whether these individuals should be participating in the health insurance market rather than having the HSN reimburse providers for their treatment.

[8] The Office matched individuals from the two lists only if they had identical first and last names and identical dates of birth. Immediately before the Office completed this report, the HSNO completed its own comparison of HSN users and taxpayers who claimed the religious exemption in calendar year 2012. In that comparison, the HSNO included claims that providers submitted after the Office received its list of HSN claims, and matched individuals whose names were spelled slightly differently and whose dates of birth were slightly different on the HSN and DOR lists. This comparison resulted in 536 individuals on whose behalf the HSN paid providers $586,561.35.

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Findings

The Office found the following regarding the Matched Group:

I. Health Care Providers Submitted 955 Claims for Reimbursement to the HSN for Services Provided to the Matched Group During Calendar Year 2012.

The members of the Matched Group received health care services in 2012 for which providers submitted 955 claims for payment from the HSN, requesting $1,131,590.54 in reimbursement. As the HSN payments cannot exceed its funding for a given year, the HSN does not always compensate providers for the claimed amount. In this case, the HSN reimbursed providers $427,541.92 for these services. This reimbursement included $322,832.63 for individuals who were eligible for the HSN and $104,709.29 for bad debt claims.

Of the 955 claims, there were:

- 624 inpatient claims for which the HSN reimbursed providers $391,455.31;
- 229 professional claims for which the HSN reimbursed providers $24,058.20; and
- 102 dental claims for which the HSN reimbursed providers $12,028.40.

To be eligible for the HSN, an individual's income must be below 400% of the federal poverty level ("FPL"). To avoid the DOR penalty for failing to obtain mandatory health insurance, an individual's income must be below 150% of the FPL. As a result, members of the Matched Group who were eligible for the HSN likely had incomes between 150% and 400% of the FPL.[9] That is not necessarily true, however, for members of the Matched Group who had bad-debt claims. As discussed above, the HSN will reimburse providers for bad debt claims without regard to the income of the person who received (but failed to pay for) the medical services.

In 2012, the 268 men and 133 women in the Matched Group received medical treatment for issues that included: chest pain; shortness of breath; hypertension; bee, wasp, or hornet stings; motor vehicle and bicycle accidents; joint pain; abdominal pain; acute laryngitis; migraines and headaches; diarrhea; skin infections and rashes; viruses; diabetes; testicular hypofunction; malaise and fatigue; menstrual disorders; liver disorders; urinary tract infections; dizziness; sexually transmitted diseases; enlarged lymph nodes; behavioral health issues; and substance

[9] The following table is based on 2012 data from the U.S. Department of Health and Human Services, which is responsible for calculating the FPL:

Family Size	150% of the FPL	400% of the FPL
1	$16,755	$44,680
2	$22,695	$60,520
3	$28,635	$76,360
4	$34,575	$92,200

Table 2: 150% and 400% of the federal poverty level in 2012. *See* http://aspe.hhs.gov/poverty/12poverty.shtml.

abuse. A list of the procedures provided to the Matched Group is attached hereto as Appendix 2. As set forth below, the relevant claim information indicates that many, if not most, of the health care services provided to the individuals in the Matched Group fell within the DOR's definition of Medical Health Care for purposes of determining whether the individual was mandated to obtain health insurance coverage.

A. Much of the Health Care Services that Members of the Matched Group Received Appear to Constitute Medical Health Care.

Pursuant to the DOR's regulations, Medical Health Care includes: acute care treatment at hospital emergency rooms, walk-in clinics, and similar facilities; that a medical doctor provides or supervises; and which health insurance policies qualifying as mandatory health insurance would customarily cover. The claim information that the Office reviewed provided general information regarding the location of the service (*e.g.*, inpatient or outpatient), the types of services provided, claim and payment amounts, and type of claim (*e.g.*, inpatient, professional, or dental), but not the specific type of professional who provided the services.[10] Accordingly, the Office cannot definitively ascertain whether members of the Matched Group received Medical Health Care.

However, based on the claim information that it did review, the Office is able to draw certain general conclusions regarding the Matched Group. For example, the HSN only reimburses for care provided at hospitals and community health centers, which indicates that the locations of the services provided to members of the Matched Group would bring those services within the definition of Medical Health Care. Whether a particular kind of treatment constitutes Medical Health Care also depends on whether a physician either supervised or provided the care. Based on the fact that the HSN reimburses only for services provided in a community health center or hospital, it is likely that a physician either supervised or provided the treatment. For example, a physician must either provide or supervise all services that involve the practice of medicine in a community health center with a Department of Public Health license. 105 CMR § 140.313(A). Similarly, hospitals that are subject to the Department of Public Health's licensure regulations cannot discharge or transfer a patient without a physician's order (except for a patient who leaves against medical advice), and accordingly, physicians have a supervisory role in the care provided in the emergency room and inpatient units. 105 CMR § 130.343(H). In either a hospital or clinic, most non-physician health care providers must practice under a physician's supervision. *See*, *e.g.*, 263 CMR § 5.05 (physician assistants). Consequently, it appears that medical doctors would have had a role in either supervising or providing the vast majority of the services that the members of the Matched Group received.

Finally, whether health care treatment constitutes Medical Health Care depends on whether health insurance policies that qualify as mandatory health insurance would customarily cover that particular type of treatment. In 2012, mandatory health insurance included coverage for: ambulatory patient services, including day surgery and related anesthesia; diagnostic imaging and screening procedures, including x-rays; emergency services; hospitalization (including

[10] The Office reviewed claim information from the HSNO, MMIS, and the Data Warehouse.

inpatient acute care services that an acute care hospital generally provided); maternity and newborn care; medical and surgical care, including preventative and primary care; mental health treatment; substance abuse services; prescription drugs; and radiation therapy and chemotherapy. 956 CMR § 5.03(1)(a) (2012). The claims submitted on behalf of members of the Matched Group listed services that include: emergency room and office visits; a wide variety of blood tests; CT scans; treatment of bone fractures; MRIs; x-rays; inhalation treatments; arthroscopy; cancer screenings; electrocardiograms; mammographies; intravenous infusions; colonoscopies; and ultrasounds. These examples, along with the vast majority of the services listed in Appendix 2, fall within the description of services for which insurance policies qualifying as mandatory health insurance would likely have paid.

In short, although the Office cannot definitively state that all of the health care treatment received by members of the Matched Group constituted Medical Health Care, review of information provided by the HSNO and the claim information contained in MMIS and the Data Warehouse indicates that most of the care likely fell within the definition of Medical Health Care. Receipt of such health care services during the same year in which individuals claimed the religious exemption is inconsistent with the statutory and regulatory framework governing the exemption.

B. A Minority of the Health Care Services that Members of the Matched Group Received do not Appear to Constitute Medical Health Care.

Providers also submitted approximately 170 claims, or 17% of the 955 claims, to the HSN for services that do not appear to fall within the definition of Medical Health Care. The DOR defines treatment that falls outside of the definition of Medical Health Care as that which a non-medical doctor administers (such as chiropractic treatment, preventive dental care, mid-wifery, personal care assistance, and eye examinations in situations not customarily covered by health insurance policies), physical examinations required by third parties such as a prospective employer, and vaccinations. For example, the 102 dental claims that providers submitted on behalf of members of the Matched Group appear to include preventative dental care, such as: periodic, comprehensive, and limited oral examinations; x-rays; fillings; and periodontal scaling. This type of preventive dental care likely would not constitute Medical Health Care for purposes of the religious exemption. These dental claims are distinct, however, from claims that providers submitted for dental care that appeared to be unexpected, such as treatment in an emergency room for cracked or broken teeth that resulted from a fall or other trauma. The incidents involving emergency dental care do not appear to have been routine and would therefore constitute Medical Health Care.

Similarly, the definition of Medical Health Care excludes vaccinations. Members of the Matched Group received a number of vaccinations, including those against Hepatitis B, HPV, influenza, and pneumonia, as well as tetanus, diphtheria, and pertussis vaccinations. The vast majority of the vaccinations occurred while the members of the Matched Group received some other kind of treatment (*e.g.*, office visit for treatment of a urinary obstruction during which the member of the Matched Group received an influenza vaccination), and the claim that the provider submitted included the vaccination among all of the services provided. The claim information that the Office reviewed appears to show that only four members of the Matched

Group went to a community health center or hospital for the sole purpose of receiving a vaccination.

Finally, the claim information indicates that members of the Matched Group received a limited number of other services that a physician may not have provided or supervised, such as physical therapy (two individuals), psychotherapy (six individuals), and nutrition education (seven individuals). Looking at all of the services that members of the Matched Group received, it appears that only four individuals in the Matched Group received no services that constitute Medical Health Care.

In summary, the Office identified a limited number of claims for services that do not appear to be included within the definition of Medical Health Care. However, in 2012 all but four individuals in the Matched Group received treatment that appears to qualify as Medical Health Care, which is contrary to the purpose underlying the applicable statutes and regulations governing the religious exemption.

C. Members of the Matched Group Had the Opportunity to Disclose on the 2012 Schedule HC that They Had Received Health Care Services for that Calendar Year.

Taxpayers file the Schedule HC as part of their tax returns, on which each taxpayer attests that the return and enclosures are true, correct, and complete under the penalties of perjury. If a member of the Matched Group received Medical Health Care in 2012, he had an opportunity – indeed, an obligation – to indicate that fact when he was filling out the Schedule HC. If a taxpayer did indicate on the Schedule HC that he had received Medical Health Care during 2012, he would then have had to answer additional questions on the Schedule HC regarding the availability of health insurance coverage. However, none of the members of the Matched Group indicated on the Schedule HC that they had received Medical Health Care during 2012.

II. Many Individuals in the Matched Group Have a History of Enrollment in a Publicly-Funded Health Care Program or Eligibility for the HSN.

In addition to being eligible for the HSN in 2012, many individuals in the Matched Group have a history of being enrolled in or eligible for a public health program, such as MassHealth or the HSN.[11] As with many enrollees in public health programs, the members in the Matched Group were enrolled and disenrolled in a variety of programs over time. Review of the claim and eligibility information in the Data Warehouse and MMIS revealed that at least 287, or 71%, of the 401 individuals of the Matched Group were enrolled in or eligible for one or more public health program in the five years before filing for the religious exemption in 2012. Further, at least 221 individuals in the Matched Group, or 55%, had a history of enrollment in or eligibility

[11] Generally speaking, MassHealth currently administers seven different types of coverage (Standard, CommonHealth, CarePlus, Family Assistance, Small Business Employee Premium Assistance, Limited, and Senior Buy-In) and three additional distinct benefit programs (Children's Medical Security Plan, Healthy Start, and the HSN).

for one or more public health programs before 2007, and at least 284, or 70%, were enrolled in or eligible for a public health program after 2012. Looking just at the HSN for calendar year 2011, for instance, providers submitted 322 inpatient, 177 professional, and 43 dental claims on behalf of individuals in the Matched Group, requesting $579,915.53 in reimbursement, for which the HSN paid providers $236,923.01.

It is important to note that enrollment in or eligibility for a public health program does not equate with the receipt of health care services (or Medical Health Care). For example, there are times when an individual applies for a non-medical benefit program and is automatically enrolled in a MassHealth program. Depending on the circumstances, enrollment or eligibility without receipt of Medical Health Care may be consistent with the framework of the religious exemption. However, receiving health care services, regardless of whether an individual applied to the public program paying for the treatment, is inconsistent with claiming the religious exemption.

Many members of the Matched Group have such a history. Information from the HSNO, MMIS, and the Data Warehouse highlights the degree to which these individuals have had ongoing involvement in the health care system. For example, Person A has enrolled in or been eligible for the following public health programs:

MassHealth Standard:	April 1992 to May 2009
MassHealth Prenatal:	April 1995 to June 1995
MassHealth Standard:	March 1995 to March 2000
MassHealth Standard:	January 2008 to April 2009
Health Safety Net:	April 2009 to August 2009
Health Safety Net:	August 2009 to September 2009
MassHealth Standard:	August 2009 to January 2012
Health Safety Net:	January 2012
Commonwealth Care:	January to June 2012
Commonwealth Care:	September 2012 to September 2013
MassHealth Standard:	September 2013 to December 2299[12]

Another person from the Matched Group, Person B, has enrolled in or been eligible for the following public health programs:

MassHealth Standard:	March 2004 to April 2005
MassHealth Standard:	January 2006 to July 2008
MassHealth Standard:	August 2008 to October 2009
Commonwealth Care:	October 2009 to October 2011
Health Safety Net:	May 2011
Commonwealth Care:	February to April 2012
Partial Health Safety Net:	April to October 2012
Commonwealth Care:	October 2012 to July 2013
Partial Health Safety Net:	July 2013 to December 2299

[12] MMIS and the Data Warehouse appear to use a year such as "2299" to indicate that there is no termination date for enrollment in a particular program.

A third person from the Matched Group, Person C, has enrolled in or been eligible for the following public health programs:

MassHealth Standard:	November 2003 to May 2006
Health Safety Net:	May 2006 to January 2007
Commonwealth Care:	January 2007 to September 2008
Health Safety Net:	July to November 2011
MassHealth Standard:	August 2008 to September 2012
Health Safety Net:	August to November 2012
Commonwealth Care:	November 2012 to December 2013
MassHealth Care Plus:	January 2014 to December 2299

A fourth person from the Matched Group, Person D, has enrolled in or been eligible for the following public health programs:

MassHealth Basic Managed Care:	March 2001 to April 2002
MassHealth Family Assistance:	April 2002 to August 2003
Partial Health Safety Net:	September to October 2005
MassHealth Standard:	October 2005 to January 2006
MassHealth Standard:	March 2006 to January 2007
MassHealth Standard:	May to June 2007
Health Safety Net:	January to April 2012
Partial Health Safety Net:	March 2012 to January 2013
MassHealth Standard:	January 2013 to December 2299

A fifth person from the Matched Group, Person E, has enrolled in or been eligible for the following public health programs:

Health Safety Net:	February 2005 to February 2007
Commonwealth Care:	February 2007 to August 2008
Commonwealth Care:	September 2008 to August 2011
Health Safety Net:	December 2010 to January 2011
Partial Health Safety Net:	August to December 2011
Commonwealth Care:	January to February 2012
Partial Health Safety Net:	February to August 2012
Health Safety Net:	August 2012 to March 2013
Commonwealth Care:	February 2013 to March 2014

A sixth person from the Matched Group, Person F, has enrolled in or been eligible for the following public health programs:

MassHealth Standard:	March 1979 to December 2001
MassHealth Standard:	June 2002 to June 2003
Health Safety Net:	April to May 2005
Commonwealth Care:	December 2007 to April 2008
Health Safety Net:	April 2008 to March 2009
Health Safety Net:	October to November 2010

Commonwealth Care:	November 2010 to September 2011
Commonwealth Care:	December 2011 to December 2013
Health Safety Net:	August 2011 to February 2012
MassHealth Care Plus:	January 2014 to December 2299

Information from the HSN Office and the Data Warehouse reveals that five out of six of these members of the Matched Group have received routine medical examinations. The diagnoses associated with these six individuals include abdominal pain, alcohol dependence and abuse, anemia, ankle fracture, asthma, autoimmune disease, bipolar manic episodes, bronchitis, chest pain, chronic fatigue syndrome, cocaine dependence, coronary atherosclerosis, depression, dermatological issues, diabetes, esophageal reflux, general anxiety disorder, hammer toe, hemorrhoids, hepatitis B, high cholesterol, human immunodeficiency virus, hypertension, hypotension, hypothyroidism, inflammation of lower back nerves, joint pain, lumbago, migraine headaches, muscle pain, nausea and vomiting, neck pain, post-traumatic stress disorder, psychosis, recurrent major depressive affective disorder, renal distress, respiratory abnormality, restless leg syndrome, shoulder sprain, sinusitis, thyroid disorder, and tonsillitis.

These are just six examples from the Matched Group that demonstrate a substantial history of enrollment in and eligibility for public health programs, as well as receipt of a wide variety of medical treatment. Looking more broadly at the members of the Matched Group with a history of eligibility for and enrollment in public health programs, these individuals appear to be active participants in the health care system who would likely derive substantial benefit from health insurance. In light of the historical information regarding many of the members of the Matched Group, their claims of religious exemption appear to be contrary to both the language and intent of the exemption.

III. Many of the Individuals Who Filed for the Religious Exemption Were Under the Age of 50.

A brief overview of the demographics of the individuals who filed for the religious exemption is relevant, in conjunction with their history of health care treatment, because it raises further concerns about the claimed exemptions. There was a large percentage of 18- to 34-year-olds – so-called "young and healthies – who filed for the religious exemption in 2012, with almost half of the Matched Group falling within this demographic. The "young and healthies" are important to the health insurance market because insurers need a wide range of people signing up for health insurance coverage as their premiums help to offset the cost of providing coverage to older and sicker individuals who tend to generate more in medical bills than they contribute in premiums. The United States Census Bureau estimated that there were 5,244,729 adult Massachusetts residents in 2012, of which approximately 44% were between 18 and 50 years old:

Age	Total # in MA	% of MA population
0-17	1,401,415	21.08%
18-29	1,150,589	17.31%
30-49	1,778,251	26.75%
50-64	1,357,395	20.42%
65+	958,494	14.42%
Total	6,646,144	99.98%

Table 3: Massachusetts population by age

However, the vast majority of the individuals who filed for the religious exemption for 2012 – almost 80% – were under the age of 50:

Age range	Total # Exemptions by Age	% Exemptions by Age
18-29	2,338	32.66%
30-49	3,387	47.32%
50-64	1,283	17.92%
65+	127	1.77%
Unknown	22	0.31%
Total	7,155	99.98%

Table 4: Religious exemption by age

Narrowing the focus to 18- to 34-year-olds in the Matched Group, there were 233, or 58%, who both filed for the exemption and received health services for which providers submitted claims to the HSN.[13] The history of enrollment in or eligibility for public health programs by these "young and healthies," along with their receipt of health care treatment, raises the question as to whether these individuals should be participating in the health insurance market rather than having the HSN reimburse providers for their treatment.

[13] Indeed, 3,595 individuals between the ages of 18 and 34 filed for the religious exemption in 2012, which is approximately half of all Massachusetts taxpayers who filed for the exemption.

Recommendations

Based on the findings above, the Office makes the following recommendations:

I. The HSN Office and the DOR Should Conduct an Annual Data Match.

Pursuant to G.L. c. 62C, § 21(b)(23), the DOR may disclose tax return information to EOHHS to determine if a taxpayer who claimed the religious exemption also received health services for which the HSN reimbursed a provider. Based on the findings in this report, the Office recommends that the HSN Office and the DOR conduct this match annually to determine whether there are individuals filing for the religious exemption who are receiving Medical Health Care for which providers are submitting claims to the HSN. As a result of the Office's review, the HSN Office and the DOR recently conducted this match for calendar year 2012, and the DOR is in the process of analyzing its next steps with regard to that group of taxpayers.

II. The DOR Should Conduct an Annual Data Match with MassHealth.

Although this report has focused on the HSN, the Legislature also requires the Office to conduct an annual study of MassHealth. Based on the finding that over half of the individuals in the Matched Group were enrolled in or eligible for one or more public health programs between 2007 and 2012,[14] the Office recommends that the DOR and MassHealth conduct this match annually to determine whether there are individuals receiving Medical Health Care for which MassHealth is paying.

Pursuant to G.L. c. 62C, § 21(b)(22), the DOR may disclose any non-financial information contained in an individual tax return to EOHHS "under an interagency agreement for the enforcement or administration of chapter 118E[,]" which provides the statutory framework for MassHealth and the HSN. In addition, G.L. c. 62C, § 21(b)(23), permits the DOR to disclose information contained in an individual tax return to EOHHS to allow the DOR to verify MassHealth coverage. The Office recommends that MassHealth and the DOR determine whether these statutory references are sufficient to allow them to conduct these matches.

III. The DOR Should Conduct at Least One Match Against the Center for Health Information and Analysis's All-Payer Claims Database.

The Center for Health Information and Analysis ("CHIA") maintains the All-Payer Claims Database, which contains medical, pharmacy, and dental claims, as well as information about health care eligibility, for all Massachusetts residents. Chapter 111M of the General Laws provides that:

> The department of revenue and the center for health information and analysis may conduct data matches for the purposes of administering this section. The center

[14] *See supra* at pp. 16-19.

> may disclose to the department whether a health care provider has submitted data indicating that it has provided health care services during the relevant tax year to an individual claiming an exemption under this section. [G.L. c. 111M, § 3.]

The Office did not review whether any individuals who filed for the religious exemption received Medical Health Care for which a private insurer paid. However, the Office recommends that the DOR work with CHIA to conduct a one-time match against the All-Payer Claims Database to determine whether any individuals who filed for the religious exemption have had claims filed on their behalf during the same time period for which they filed for the exemption. Depending on the outcome, the DOR should consider whether conducting this match on an ongoing basis would assist in identifying individuals who are both filing for the religious exemption and receiving Medical Health Care. Performing this match will allow the DOR, which has collected $119 million since 2008 against individuals who did not maintain mandated health insurance, to enforce the health insurance requirement equitably. The DOR will thereby ensure that individuals who claim the religious exemption are complying with the applicable statutes and regulations.

IV. The DOR Should Consider Exercising its Regulatory Authority to Examine Claims of Exemption.

In promulgating the regulations that govern the religious exemption, the DOR reserved to itself the right to "question a claim of exemption where facts are sufficiently extreme as to cast doubt on the sincerity of the religious beliefs asserted." 830 CMR § 111M.2.1(6)(b)(2). If the DOR finds through the data comparisons recommended above that individual taxpayers claimed the religious exemption while receiving Medical Health Care, the Office recommends that the DOR consider reviewing and questioning those claims of exemption. For instance, the DOR might consider reviewing those individuals whose medical claims were submitted to the HSN as bad debt. Providers are reimbursed for bad debt without regard to the income of the person who received (but failed to pay for) the medical services. The DOR could quickly ascertain whether these individuals, who have passed no eligibility review, have sufficient income to make further review worthwhile. Although this report focused on individuals who were eligible for the HSN, the DOR could also review individuals who claimed the exemption but who did not receive health care services through a publicly-funded health care program such as the HSN or MassHealth.

Upon further examination, it may be that an individual's income is below 150% of the FPL and as such is not subject to a penalty, that the treatment a particular individual received did not constitute Medical Health Care, or that an individual received Medical Health Care under unique circumstances that merit further consideration. Regardless of the ultimate outcome, the findings in this report indicate that the DOR should consider examining at least some claims of the religious exemption, and should evaluate whether to impose penalties against individuals who have improperly claimed the religious exemption.

The findings in this report also raise the question as to whether the threshold for the penalty for not obtaining health insurance – 150% of the federal poverty level – is set at the correct level. The Office recommends that the DOR consider reviewing the findings contained in this report with the Massachusetts Health Insurance Connector Authority with this question in mind.

V. For Individuals Whose Names Appear on the HSN Matched List, the HSN Office Should Consider Whether There Is Appropriate Health Insurance Coverage Available.

If the HSN Office works with the DOR to conduct the recommended match, the HSN Office should consider reviewing whether there might be other health care programs for which the matched individuals are eligible. The finding that many members of the Matched Group have received health care treatment over the years suggests that these individuals may be in need of health care coverage, but that for some reason they are not availing themselves of such coverage. The Office recognizes that the HSN eligibility process should screen out individuals who are eligible for other types of health care coverage, and the Office also recognizes that the HSN cannot force individuals to apply for or enroll in a particular type of coverage. However, the Office recommends that the HSN Office work with partners, such as MassHealth and the Massachusetts Health Insurance Connector Authority, to determine the potential availability of programs for individuals who are both claiming the religious exemption and are receiving health care treatment to ensure that the HSN is truly the payor of last resort.

VI. The DOR Should Consider Changing Part of Schedule HC to Clarify that the Individual's Religious Beliefs Must Relate to Medical Treatment, Not Paying for Insurance.

The Office recommends that the DOR consider changing its forms and instructions to clarify that the exemption is for individuals whose religious beliefs preclude them from receiving medical treatment, rather than paying for health insurance.

The DOR's 2012 Schedule HC provides that a taxpayer may claim the religious exemption if his sincere religious belief is the basis for his "refusal to obtain and maintain health insurance coverage." The schedule also asks: "Are you claiming an exemption from the requirement to purchase health insurance based on your sincerely held religious beliefs?" (The 2013 Schedule HC documents contain identical language.) Similarly, the 2012 Line by Line Instructions for the religious exemption section of the Schedule HC state that:

> A religious exemption is available for anyone who has a sincere religious belief that is the basis of refusal to obtain and maintain health insurance coverage. Fill in the Yes oval(s) if you are claiming a religious exemption from the requirement to purchase health insurance based on your sincerely held religious beliefs.

The language quoted above is confusing because it implies that a person may be entitled to the exemption if he has a religious objection to purchasing health insurance. It is possible that some of the Matched Group erroneously filed for the religious exemption based on this confusion.

The DOR regulatory Scope of Exemption interprets the religious exemption as an acknowledgment 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." The DOR regulation appears to more accurately capture the underlying purpose of the exemption than the language contained in the Schedule HC documents.

The Office therefore recommends that the DOR consider amending the Line by Line Instructions and the Schedule HC to reflect its regulatory language. Thus, the Line by Line Instructions could read:

> A religious exemption is available for anyone who has a sincere religious belief that *would cause the person to object to substantially all forms of treatment covered by health insurance, and therefore is* the basis of refusal to obtain and maintain health insurance coverage. Fill in the Yes oval(s) if you are claiming a religious exemption from the requirement to purchase health insurance based on your sincerely held religious beliefs *that cause you to object to substantially all forms of treatment covered by health insurance*.

And the Schedule HC could read:

> Are you claiming an exemption from the requirement to purchase health insurance based on your sincerely held religious beliefs *that cause you to object to substantially all forms of treatment covered by health insurance*?

These small changes would clarify the purpose of the exemption, and reduce or eliminate the possibility that individuals are erroneously filing for the religious exemption.

Conclusion

The Legislature created the religious exemption to the requirement that all Massachusetts adults have health insurance as an acknowledgment that there are individuals who hold sincere religious beliefs which would cause them decline substantially all forms of health care treatment that health insurance would ordinarily cover. For those individuals, a claim of religious exemption from the individual mandate is consistent with the applicable statutes and regulations. It is not, however, consistent with those statutes and regulations for individuals to claim the religious exemption, not obtain any health insurance coverage, and then receive health care services for which the HSN or another publicly-funded program pays.

The Office's review indicates that there are a number of individuals who are claiming the religious exemption even though they received health care treatment during the year for which they claimed the exemption, and even though they have a substantial history of participation in the health care system. This is contrary to both the intent and letter of the law, and the HSN should not be in the position of paying for health care if individuals should be purchasing health insurance. This is also unfair to the Massachusetts residents who have obtained and maintained health insurance coverage, as well as to those who have paid the penalty for not having such coverage.

The HSN Office and the DOR should work together to determine which individuals are claiming the religious exemption while obtaining health care for which the HSN is providing reimbursement; MassHealth and CHIA should also collaborate with the DOR to perform the same type of analysis. Once these agencies have identified these individuals, there should be an effort made to understand why they are claiming the exemption and to determine the proper response. The DOR should also consider revising its forms to ensure that taxpayers are not erroneously claiming the exemption.

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Appendix 1: 2012 Schedule HC Health Care Information Form and 2012 Line by Line Instructions

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FULL-YEAR RESIDENTS AND CERTAIN PART-YEAR RESIDENTS MUST COMPLETE AND ENCLOSE SCHEDULE HC WITH RETURN.

FIRST NAME | M.I. | LAST NAME | SOCIAL SECURITY NUMBER

Schedule HC Health Care Information. You must enclose this schedule with Form 1 or Form 1-NR/PY. 2012

1 **a.** Date of birth ► **b.** Spouse's date of birth ► **c.** Family size ► (see instructions)

2 Federal adjusted gross income (**required** information). If married filing separately, see instructions (from U.S. Forms 1040, line 37; 1040A, line 21; or 1040EZ, line 4). . . . . ► **2** 0 0

3 Indicate the time period that you were enrolled in a Minimum Creditable Coverage (MCC) health insurance plan(s). You **must** fill in an oval. The Form MA 1099-HC from your insurer will indicate whether your insurance met MCC requirements. **Note:** MassHealth, Commonwealth Care, Commonwealth Care Bridge, Medicare, and health coverage for U.S. Military, including Veterans Administration and Tri-Care, meet the MCC requirements. If you did not receive a Form MA 1099-HC from your insurer, or you had insurance that did not meet MCC requirements, see the section on MCC requirements in the instructions.

► **3a** You: ○ Full-year MCC ○ Part-year MCC ○ No MCC/None

► **3b** Spouse: ○ Full-year MCC ○ Part-year MCC ○ No MCC/None

Note: See instructions if, during 2012, you turned 18, you were a part-year resident or a taxpayer was deceased.

If you filled in the full-year or part-year MCC oval, go to line 4. If you filled in No MCC/None, go to line 6.

4 Indicate the health insurance plan(s) that met the Minimum Creditable Coverage (MCC) requirements in which you were enrolled in 2012, as shown on Form MA 1099-HC (check all that apply). If you did not receive this form, fill in the oval in line(s) 4f and/or 4g and see instructions. If you were enrolled in private insurance and MassHealth, Commonwealth Care or Commonwealth Care Bridge, fill in the ovals, enter your private insurance information in line(s) 4f and/or 4g and go to line 5.

4a	Private insurance (complete lines 4f and/or 4g below). If more than two, complete Schedule HC-CS.	**4a** ○ You	○ Spouse
4b	MassHealth, Commonwealth Care or Commonwealth Care Bridge. Fill in oval(s) and go to line 5.	**4b** ○ You	○ Spouse
4c	Medicare (including a replacement or supplemental plan). Fill in oval(s) and go to line 5.	**4c** ○ You	○ Spouse
4d	U.S. Military (including Veterans Administration and Tri-Care). Fill in oval(s) and go to line 5.	**4d** ○ You	○ Spouse
4e	Other government program (enter the program name(s) **only** in lines 4f and/or 4g below). **Note:** Health Safety Net is not considered insurance or minimum creditable coverage.	**4e** ○ You	○ Spouse

4f **YOUR HEALTH INSURANCE. Complete if you answered line(s) 4a or 4e and go to line 5.** ○ Fill in if you were not issued Form MA 1099-HC

1. NAME OF PRIVATE INSURANCE COMPANY, ADMINISTRATOR OR OTHER GOVERNMENT PROGRAM (from box 1 of Form MA 1099-HC)

FEDERAL IDENTIFICATION NUMBER OF INSURANCE CO. (from box 2 of Form MA 1099-HC) | SUBSCRIBER NUMBER (from Form MA 1099-HC)

2. NAME OF SECOND PRIVATE INSURANCE COMPANY, ADMINISTRATOR OR OTHER GOVERNMENT PROGRAM IF NECESSARY (from box 1 of Form MA 1099-HC)

FEDERAL IDENTIFICATION NUMBER OF INSURANCE CO. (from box 2 of Form MA 1099-HC) | SUBSCRIBER NUMBER (from Form MA 1099-HC)

4g **SPOUSE'S HEALTH INSURANCE. Complete if you answered line(s) 4a or 4e and go to line 5.** ○ Fill in if you were not issued Form MA 1099-HC

1. NAME OF PRIVATE INSURANCE COMPANY, ADMINISTRATOR OR OTHER GOVERNMENT PROGRAM FOR SPOUSE (from box 1 of Form MA 1099-HC)

FEDERAL IDENTIFICATION NUMBER OF INSURANCE CO. (from box 2 of Form MA 1099-HC) | SPOUSE'S SUBSCRIBER NUMBER (from Form MA 1099-HC)

2. NAME OF SECOND PRIVATE INSURANCE COMPANY, ADMINISTRATOR OR OTHER GOVERNMENT PROGRAM IF NECESSARY FOR SPOUSE (from box 1 of Form MA 1099-HC)

FEDERAL IDENTIFICATION NUMBER OF INSURANCE CO. (from box 2 of Form MA 1099-HC) | SPOUSE'S SUBSCRIBER NUMBER (from Form MA 1099-HC)

5 If you had health insurance that met MCC requirements for the **full-year**, including private insurance, MassHealth, Commonwealth Care or Commonwealth Care Bridge, you are **not** subject to a penalty. Skip the remainder of this schedule and continue completing your tax return.

If you had Medicare (including a replacement or supplemental plan), U.S. Military (including Veterans Administration and Tri-Care), or other government insurance at any point during 2012, you are not subject to a penalty. Skip the remainder of this schedule and continue completing your tax return.

If you filled in the Part-year MCC or No MCC/None oval in line 3, you must complete line 6.

BE SURE YOU FILLED IN LINES 2 & 3 ABOVE. YOU MUST COMPLETE AND ENCLOSE SCHEDULE HC WITH YOUR RETURN.

Attach, with a single staple, copy of Form MA 1099-HC, if applicable.

FIRST NAME | M.I. | LAST NAME | SOCIAL SECURITY NUMBER

Uninsured for All or Part of 2012

6 Was your income in 2012 at or below 150% of the federal poverty level (see worksheet)? ▶ **6** ◯ Yes ◯ No

If you answer **Yes**, you are not subject to a penalty in 2012. Skip the remainder of this schedule and complete your tax return. If you answer **No** and you were enrolled in a health insurance plan that met the MCC requirements for part, but not all, of 2012, go to line 7. If you answer **No** and you had no insurance or you were enrolled in a plan that did not meet the MCC requirements during the period that the mandate applied, go to line 8a.

7 Complete this section **only** if you, and/or your spouse if married filing jointly, were enrolled in a health insurance plan(s) that met the Minimum Creditable Coverage (MCC) requirements for part, but not all of 2012. Fill in the ovals below for the months that met the MCC requirements, as shown on Form MA 1099-HC. If you did not receive this form, fill in the ovals for the months you were covered by a plan that met the MCC requirements at least **15 days or more**. If, during 2012, you **turned 18**, you were a **part-year resident** or a taxpayer was **deceased**, fill in the oval(s) below for the month(s) that met the MCC requirements during the period that the mandate applied. See instructions.

You may **only** fill in the oval(s) for the month(s) you had health insurance that met MCC requirements. If you had health insurance, but it did not meet MCC requirements, you must skip this section and go to line 8a.

MONTHS COVERED BY HEALTH INSURANCE THAT MET MINIMUM CREDITABLE COVERAGE

	JAN	FEB	MARCH	APRIL	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC
YOU:	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
SPOUSE:	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

If you had four or more consecutive months either with no insurance or insurance that did not meet the MCC requirements (four or more blank ovals in a row), go to line 8a. Otherwise, a penalty does not apply to you in 2012. Skip the remainder of this schedule and complete your tax return.

Religious Exemption and Certificate of Exemption

8 **a. RELIGIOUS EXEMPTION.** Are you claiming an exemption from the requirement to purchase health insurance based on your sincerely held religious beliefs? ▶ **8a** You: ◯ Yes ◯ No Spouse: ◯ Yes ◯ No

If you answer **Yes**, go to line 8b. If you answer **No**, go to line 9. If you are filing a joint return and one spouse answers **Yes** but the other spouse answers **No**, see instructions.

b. If you are claiming a religious exemption in line 8a, did you receive medical health care during the 2012 tax year? ▶ **8b** You: ◯ Yes ◯ No Spouse: ◯ Yes ◯ No

If you answer **No** to line 8b, skip the remainder of this schedule and continue completing your tax return. If you answer **Yes** to line 8b, go to line 9. If you are filing a joint return and one spouse answers **Yes** but the other spouse answers **No**, see instructions.

9 **CERTIFICATE OF EXEMPTION.** Have you obtained a Certificate of Exemption issued by the Commonwealth Health Insurance Connector Authority for the 2012 tax year? ▶ **9** You: ◯ Yes ◯ No Spouse: ◯ Yes ◯ No

If you answer **Yes**, enter the certificate number below, skip the remainder of this schedule and continue completing your tax return. If you answer **No** to line 9, go to line 10. If you are filing a joint return and one spouse answers **Yes** but the other spouse answers **No**, see instructions.

YOUR CERTIFICATE NUMBER

SPOUSE'S CERTIFICATE NUMBER

BE SURE TO ENCLOSE SCHEDULE HC WITH YOUR RETURN.

FIRST NAME | M.I. | LAST NAME | SOCIAL SECURITY NUMBER

Affordability as Determined By State Guidelines

NOTE: This section will require the use of worksheets and tables. You **must** complete the worksheet(s) to determine if health insurance was affordable to you during the 2012 tax year.

10 Did your employer offer affordable health insurance that met the minimum creditable coverage requirements as determined by completing the Schedule HC Worksheet for Line 10? ► **10** You: ○ Yes ○ No Spouse: ○ Yes ○ No

If your employer did not offer health insurance that met the minimum creditable coverage requirements, you were not eligible for health insurance offered by your employer, you were self-employed or you were unemployed, fill in the **No** oval.

If you answer **No**, go to line 11. If you answer **Yes**, go to the Health Care Penalty Worksheet to calculate your penalty amount.

11 Were you eligible for government-subsidized health insurance as determined by completing the Schedule HC Worksheet for Line 11? ► **11** You: ○ Yes ○ No Spouse: ○ Yes ○ No

If you answer **No**, go to line 12. If you answer **Yes**, go to the Health Care Penalty Worksheet to calculate your penalty amount.

12 Were you able to purchase affordable private health insurance that met the minimum creditable coverage requirements as determined by completing the Schedule HC Worksheet for Line 12? ► **12** You: ○ Yes ○ No Spouse: ○ Yes ○ No

If you answer **No**, you are not subject to a penalty. Continue completing your tax return. If you answer **Yes**, go to the Health Care Penalty Worksheet to calculate your penalty amount.

Complete Only If You Are Filing an Appeal

You must complete the Health Care Penalty Worksheet to determine your penalty amount before completing this section.

You may have grounds to appeal if you were unable to obtain affordable insurance that meets the minimum creditable coverage requirements in 2012 due to a hardship or other circumstances. The grounds for appeal are explained in more detail in the instructions. If you believe you have grounds for appealing the penalty, fill in the oval(s) below. The appeal will be heard by the Commonwealth Health Insurance Connector Authority. By filling in the oval below, you (or your spouse if married filing jointly) are authorizing DOR to share information from your tax return, including this schedule, with the Connector Authority for purposes of deciding your appeal.

Important Information If You Are Filing An Appeal:

You will receive a follow-up letter asking you to state your grounds for appeal in writing, and submit supporting documentation. Failure to respond to that letter within the time specified in the letter will lead to dismissal of your appeal and will result in a future assessment of a penalty.

Once your documentation is received, it will be reviewed by the Commonwealth Health Insurance Connector Authority and you may be required to attend a hearing on your case. You will be required to file your claims under the pains and penalties of perjury.

Note: If you are filing an appeal, make sure you have calculated the penalty amount that you are appealing, but do **not** assess yourself or enter a penalty amount on your Form 1 or Form 1-NR/PY. Also, do not include any hardship documentation with your original return. You will be required to submit substantiating hardship documentation at a later date during the appeal process.

YOU: ○ I wish to appeal the penalty. I authorize DOR to share this tax return including this schedule with the Commonwealth Health Insurance Connector Authority for purposes of deciding this appeal.

SPOUSE: ○ I wish to appeal the penalty. I authorize DOR to share this tax return including this schedule with the Commonwealth Health Insurance Connector Authority for purposes of deciding this appeal.

BE SURE TO ENCLOSE SCHEDULE HC WITH YOUR RETURN.

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2012 Massachusetts **Schedule HC** Health Care

Special Section on Minimum Creditable Coverage

What is "Minimum Creditable Coverage" (MCC)?

It's the minimum level of health insurance benefits that adult tax filers need to be considered insured and avoid tax penalties in Massachusetts.

How do I know if my plan met MCC?

Massachusetts-licensed health insurance companies must put an MCC-compliance notice on their plans to indicate if it does or does not meet MCC. Most do meet the MCC standards. If you received a Form MA 1099-HC from your insurer, that form will indicate whether your insurance met MCC requirements. For a list of plans that automatically meet MCC, please refer to the plans listed on this page.

What if I did not receive a Form MA 1099-HC from my insurer?

You can call your insurer or your employer's human resources department or benefits administrator for help, if you get health coverage through your job. If your insurer or your employer is unable to assist you, please refer to the "Benefits Required Under MCC" section on this page to see if your policy meets these requirements. If your plan meets all of the requirements, you may certify in line 3 of the Schedule HC that you were enrolled in a plan that met the MCC requirements during that time period.

What if my plan did not meet MCC for all of 2012?

If you were enrolled in a plan that did not meet the MCC requirements for all of 2012, you must fill in the "No MCC/None" oval in line 3 of the Schedule HC and follow the instructions on the Schedule HC. You will not be subject to a penalty if it is determined that you did not have access to affordable insurance that met MCC. If you had access to affordable insurance that met MCC but did not purchase it, you are subject to a penalty. However, if you are subject to a penalty, you may appeal and claim that the penalty should not apply to you. For more information about the grounds and procedure for appeals, go to page HC-4. No penalty will be imposed pending the outcome of your appeal.

What if I was enrolled in an MCC plan for only part of the year?

If you were enrolled in an MCC plan for only part of the year, you should fill in the "Part-Year MCC" oval in line 3 of the Schedule HC and go to line 4. In line 4, only provide the health insurance information for the MCC plan(s) you were enrolled in. Do not provide health insurance information in line 4 for a plan that did not meet the MCC standards.

Benefits Required Under MCC

For most plans, the 2012 "Minimum Creditable Coverage" standards include:

- Coverage for a comprehensive set of services (for example: doctor visits, hospital admissions, day surgery, emergency services, mental health and substance abuse, and prescription drug coverage);
- Doctor visits for preventive care, without a deductible;
- A cap on annual deductibles of $2,000 for an individual and $4,000 for a family;
- For plans with up-front deductibles or co-insurance on core services, an annual maximum on out-of-pocket spending of no more than $5,000 for an individual and $10,000 for a family;
- No caps on total benefits for a particular illness or for a single year;
- No policy that covers only a fixed dollar amount per day or stay in the hospital, with the patient responsible for all other charges;
- For policies that have a separate prescription drug deductible, it cannot exceed $250 for an individual or $500 for a family;
- All services must be provided to all of those covered (for example, a plan that covers dependents must extend maternity services to them); and
- No cap on prescription drug benefits.

Other ways of meeting MCC:

You automatically meet MCC if you are enrolled in:

- Medicare Part A or B;
- Any Commonwealth Care, Commonwealth Care Bridge plan;
- Any Commonwealth Choice plan (including Young Adult Plans);
- MassHealth;
- A Student Health Insurance Plan (SHIP) offered in Massachusetts or another state;
- A tribal or Indian Health Service plan;
- TRICARE;
- The U.S. Veterans Administration Health System;
- A health insurance plan offered by the federal government to federal employees or retirees;
- Peace Corps, VISTA or AmeriCorps or National Civilian Community Corps coverage; or
- A Pre-Existing Condition Insurance Plan (PCIP).

Note: A federally-qualified High Deductible Health Plan (HDHP) offered with a Health Savings Account (HSA) or Health Reimbursement Arrangement (HRA) may meet MCC if it complies with most of the benefits described above.

For more information on MCC requirements, visit the Health Connector's website at www.mahealthconnector.org.

Schedule HC Instructions

Health Care Information

The Massachusetts health care reform law requires most residents 18 and over with access to affordable health insurance to obtain it. More information about the health care reform law and how to purchase affordable health insurance is available at the Commonwealth Health Insurance Connector Authority's website at www.mahealthconnector.org.

Special Circumstances During 2012

Read this section if, during 2012, you turned 18, moved into or out of Massachusetts or if you are filing a tax return on behalf of a deceased taxpayer to determine the period of time that the mandate to have health insurance applied to you.

Note: Schedule HC must be completed and filed if you fall into a "special circumstances" category.

Turning 18. If you turned 18 during 2012, the mandate to obtain and maintain health insurance applies to you beginning on the first day of the third month following the month of your birthday. For example, if your birthday is June 15, the mandate applies on September 1.

Part-year residents. If you moved into Massachusetts during 2012, the mandate to obtain and maintain health insurance applies to you beginning on the first day of third month following the month you became a resident of Massachusetts. For example, if you moved into Massachusetts on May 14, the mandate applies on August 1.

If you moved out of Massachusetts during 2012, the requirement to obtain and maintain health insurance applies to you up until the last day of the last full month you were a resident. For example, if you moved out of Massachusetts on July 10, the mandate applies up to June 30. And, if you moved out of Massachusetts on September 30, the mandate applies up to September 30.

Note: Part-year residents are **not** required to file Schedule HC if they were residents of Massachusetts for less than three full months.

Deceased taxpayer. If a taxpayer dies during 2012, the mandate to obtain and maintain health insurance applies to the deceased taxpayer up until the last day of the last full month the taxpayer was alive. For example, if a taxpayer dies on August 4, the mandate applies up to July 31.

Lines 1a and 1b. Date of Birth

Enter your date of birth and the date of birth for your spouse (if married filing jointly).

Taxpayers turning 18 during 2012. Taxpayers with a date of birth on or after October 1, 1994 should only complete line 1 of Schedule HC because they are not subject to a penalty.

Note: Failure to enter this information will delay the processing of your return.

Line 1c. Family Size

Enter your family size, including yourself, your spouse (if living in the same household at any point during the year) and any dependents as claimed on Form 1, line 2b or Form 1-NR/PY, line 4b. If married filing separately **and** living in the same household at any point during the year, also be sure to include in line 1c any dependents claimed on your tax return and any dependents claimed by your spouse on your spouse's tax return.

Note: Failure to enter this information will delay the processing of your return.

Line 2. Federal Adjusted Gross Income

Enter your federal adjusted gross income (from U.S. Form 1040, line 37; Form 1040A, line 21; or Form 1040EZ, line 4). If married filing separately **and** living in the same household, each spouse must combine their income figures from their separate U.S. returns when completing this section. Also, same-sex spouses filing a Massachusetts joint return or married filing separately **and** living in the same household must combine their income figures from their separate U.S. returns when completing this section.

Note: Failure to enter this information will delay the processing of your return.

Line 3. Your Health Insurance Status in 2012

If you had health insurance in 2012, you must first determine if the insurance you had met the Minimum Creditable Coverage requirements. Your Form MA 1099-HC sent to you by your insurer will give you this information. Almost all state and government sponsored insurance plans, such as MassHealth, Commonwealth Care, Commonwealth Care Bridge, Medicare, and health coverage for U.S. Military, including Veterans Administration and Tri-Care, meet these requirements.

Important information: The Health Safety Net is not health insurance, and thus it does not meet MCC requirements. If this is the only way in which your health care needs were paid for in 2012, you must fill in the No MCC/None oval in line 3 and go to line 6.

If you did not receive Form MA 1099-HC from your insurer, see the special section on MCC requirements. Once you have determined whether your coverage met the MCC requirements in 2012, enter the period of time that you were covered by the plan(s).

Explanation of time periods for line 3 of Schedule HC

- **Full-year MCC.** Fill in this oval if you had health insurance that met MCC requirements for the entire year of 2012 and go to line 4.
- **Part-year MCC.** Fill in this oval if you had health insurance that met MCC requirements for only part of 2012 and go to line 4. This means for the other parts of 2012, you had no health insurance at all, health insurance that did not meet MCC requirements or a combination of both.
- **No MCC/None.** Fill in this oval if you did not, at any point in 2012, have health insurance that met MCC requirements, for example, either you did not have any health insurance at all in 2012, or you only had health insurance that did not meet MCC requirements and then go to line 6.

If married filing jointly, you must respond for yourself and your spouse. If you (or your spouse, if married filing jointly) had **Full-Year** or **Part-Year MCC**, go to line 4. If you (or your spouse, if married filing jointly) had **No MCC/None**, go to line 6. If married filing jointly, and only one spouse had **Full-Year** or **Part-Year MCC**, you must complete line 4 with information regarding the spouse who had **Full-Year** or **Part-Year MCC**, and must go to line 6 for the spouse who had **No MCC/None**. If married filing separately, you only have to respond for yourself, not your spouse.

Note: Failure to enter this information will delay the processing of your return.

Special Circumstances — Important Information: If, during 2012, you turned 18, moved into or out of Massachusetts or if you are filing a tax return on behalf of a deceased taxpayer, you must first determine the period of time that the mandate applied to you. See the Special Circumstances section on this page for additional information. If you had health insurance that met the Minimum Creditable Coverage requirements for the entire period that the mandate applied to you, fill in the **Full-Year MCC** oval in line 3. If you met the requirements for only part of the time that the mandate applied to you, fill in the **Part-Year MCC** oval. If you had no insurance or insurance that did not meet the MCC requirements for the period of time that the mandate applied to you, fill in the **No MCC/None** oval.

Line 4. Your Health Insurance Plan Information

If you indicated in line 3 that you were enrolled in a health insurance plan that met the Minimum Creditable Coverage requirements for all or part of 2012, you must now fill in the oval that matches your plan. If you had more than one plan in 2012, fill in all of the ovals that apply for you and your spouse, if married filing jointly, and follow the instructions.

Line 4a. If you (and/or your spouse if married filing jointly) were enrolled in private health insurance, fill in the oval(s) in line 4a and complete line 4f (for you) and/or 4g (your spouse) using Form(s) MA 1099-HC. This form will be issued to you by your health insurance carrier or administrator, no later than January 31, 2013. **Note:** If you received Form(s) MA 1099-HC, be sure to attach to Schedule HC. If you did not receive Form(s) MA 1099-HC, fill in the oval(s) in lines 4f (for you) and/or 4g (your spouse), and enter the name of your insurance carrier or administrator and your subscriber number in line 4f and/or 4g and go to line 5. This information should be on your insurance card. If you do not know this information, contact your insurer or your Human Resources Department if your insurance is through your employer.

Note: Generally, employees or retirees of the federal, state or local governments have private health insurance and should fill in the oval(s) in line 4a and complete line 4f (for you) and/or line 4g (your spouse) and then go to line 5.

If you and your spouse were enrolled in the same health insurance, you must complete both line 4f (for you) and 4g (your spouse).

Line 4b. If you (and/or your spouse if married filing jointly) were enrolled in MassHealth, Commonwealth Care or Commonwealth Care Bridge, fill in the Yes oval(s) in line 4b and go to line 5.

Line 4c. If you (and/or your spouse if married filing jointly) were enrolled in Medicare (including a replacement or supplemental plan), fill in the oval(s) in line 4c and then go to line 5.

Note: Fill in the Medicare oval(s) even if you have a supplemental or replacement plan that you may have purchased on your own.

Line 4d. If you (and/or your spouse if married filing jointly) were enrolled in a U.S. Military, plan (including Veterans Administration and Tri-Care) fill in the oval(s) in line 4d and then go to line 5.

Line 4e. If you (and/or your spouse if married filing jointly) were enrolled in Other government health coverage fill in the oval(s) in line 4e and complete line 4f (for you) and/or 4g (your spouse) by entering the program name(s) only.

"**Other government health coverage**" includes comprehensive government-subsidized plans such as care provided at a correctional facility. Taxpayers who receive MassHealth, Commonwealth Care or Commonwealth Care Bridge should fill in the oval on line 4b. Taxpayers who receive health care through the Health Safety Net (formerly known as the Uncompensated Care Pool) should not fill in any oval in line 4 because the Health Safety Net is not health insurance, and thus it does not meet Minimum Creditable Coverage requirements.

Lines 4f and 4g. Complete only if you filled in oval(s) in line(s) 4a or 4e. Enter information in lines 4f and 4g on up to two insurance carriers each, if you (and/or your spouse if married filing jointly) were covered by multiple insurers in 2012. **Note:** If you filled in the oval(s) in line 4e, only enter the name of the program. After completing lines 4f and 4g, go to line 5.

If you (and/or your spouse if married filing jointly) had health insurance from more than two insurance carriers, fill out Schedule HC-CS, Health Care Continuation Sheet. If you file Schedule HC-CS, report your two most recent insurance carriers first on Schedule HC and use Schedule HC-CS to report the additional insurance carriers for yourself (and/or your spouse if married filing filing jointly). Schedule HC-CS is available on DOR's website at www.mass.gov/dor.

Line 5. Instructions After Completing Lines 3 and 4

If your health insurance met the Minimum Creditable Coverage requirements for all of 2012, you are not subject to a penalty. Skip the remainder of this schedule and continue completing your tax return. If you were enrolled in Medicare, U.S. Military (including Veterans Administration and Tri-Care), or other government insurance, not including MassHealth, Commonwealth Care or Commonwealth Care Bridge, at any point during 2012, you are not subject to a penalty. Skip the remainder of this schedule and continue completing your tax return. If you had health insurance that met the MCC requirements for only part of the year in 2012 or if you had no insurance in 2012, go to line 6.

Line 6. Federal Poverty Level

Individuals with income at or below 150% of the Federal Poverty Level (FPL) are not subject to a penalty for failure to purchase health insurance. Complete the Line 6, Federal Poverty Worksheet to determine if your income in 2012 was at or below 150% of the Federal Poverty Level.

Line 7. Months Covered by Minimum Creditable Coverage Health Insurance

Complete this section only if you (and/or your spouse if married filing jointly) were enrolled in a health insurance plan(s) that met Minimum Creditable Coverage requirements for part, but not all, of 2012. You are considered to have coverage for part of 2012 if you had coverage for at least 1 but less than 12 months.

If you were enrolled in a private health insurance plan that met MCC requirements (such as coverage provided by your employer or purchased on your own) or government-sponsored health insurance (examples of which include MassHealth, Commonwealth Care or Commonwealth Care Bridge), fill in the oval(s) for the months you were covered in 2012, using the information from Form(s) MA 1099-HC.

If you did not receive a Form MA 1099-HC from your insurer, fill in the oval(s) for each month in which you had coverage that met MCC requirements for 15 days or more. If you had coverage in any month for 14 days or less, you must leave the oval(s) blank.

Note for MassHealth, Commonwealth Care or Commonwealth Care Bridge enrollees: If you did not receive a Form MA 1099-HC and you answered No to line 6, please call MassHealth at 1-866-682-6745 or Commonwealth Care or Commonwealth Care Bridge at 1-877-623-6765 for a copy. If you answered Yes to line 6, you do not need to complete this section and you do not need a Form MA 1099-HC. If you answered Yes to line 6, you are not subject to a penalty. Skip the remainder of Schedule HC and continue completing your return.

If you have four or more consecutive months either with no insurance or insurance that did not meet MCC requirements (four or more blank ovals in a row), go to line 8a. Otherwise, you are not subject to a penalty. Skip the remainder of Schedule HC and continue completing your return. Be sure to enclose Schedule HC with your return.

If you are filing a joint return and one spouse has three or fewer blank ovals in a row, and the other spouse has four or more blank ovals in a row, the spouse with three or fewer blank ovals in a row is not subject to a penalty and should skip the remainder of Schedule HC. The spouse with four or more blank ovals in a row must go to line 8a.

Special Circumstances During 2012

Note: Schedule HC must be completed and filed even if you fall into a "Special Circumstances" category. Also, do not count the months that the mandate did not apply when determining if you have four or more consecutive months without health insurance.

Turning 18. If you turned 18 during 2012, the mandate to maintain and obtain health insurance applies to you beginning on the first day of the third month following the month of your birthday. For example, if your birthday is June 15, the mandate applies on September 1. In this example, do not count the months of January through August because the mandate did not apply.

Part-year residents. If you moved into Massachusetts during 2012, the mandate to obtain and maintain health insurance applies to you beginning on the first day of the third month following

the month you became domiciled in (a resident of) Massachusetts. For example, if you moved into Massachusetts on May 14, the mandate applies on August 1. In this example, do not count the months of January through July because the mandate did not apply.

If you moved out of Massachusetts during 2012, the mandate to obtain and maintain health insurance applies to you up until the last day of the last full month you were a resident. For example, if you moved out of Massachusetts on July 10, the mandate applies up to June 30. In this example, do not count the months of July through December because the mandate did not apply.

Deceased taxpayer. If a taxpayer died during 2012, the mandate to obtain and maintain health insurance applies to the deceased taxpayer up until the last day of the last full month the taxpayer was alive. For example, if a taxpayer died on August 4, the mandate applies up to July 31. In this example, do not count the months of August through December because the mandate did not apply.

Line 8. Religious Exemption

Line 8a. A religious exemption is available for anyone who has a sincere religious belief that is the basis of refusal to obtain and maintain health insurance coverage. Fill in the Yes oval(s) if you are claiming a religious exemption from the requirement to purchase health insurance based on your sincerely held religious beliefs.

If you (and your spouse if married filing jointly) answer **Yes** to line 8a, go to line 8b.

If you (and your spouse if married filing jointly) answer **No** to line 8a, go to line 9.

If you are filing a joint return and one spouse answers **No** to line 8a but the other spouse answers **Yes**, the spouse who answered **Yes** must go to line 8b and the spouse who answered **No** must go to line 9.

Line 8b. If you are claiming a religious exemption but you received medical health care during tax year 2012, such as treatment during an emergency room visit, you may be subject to a penalty if it is determined that you could have afforded health insurance.

Medical health care excludes certain treatments such as preventative dental care, certain eye examinations and vaccinations. It also excludes a physical examination when required by a third party, such as a prospective employer. For additional information, see Department of Revenue regulation 830 CMR 111M.2.1, Health Insurance Individual Mandate; Personal Income Tax Return Requirements, available on the department's website at www.mass.gov/dor.

If you (and your spouse if married filing jointly) answer **Yes** on line 8a and **No** on line 8b, the penalty does not apply to you. Skip the remainder of Schedule HC and continue completing your tax return. Be sure to enclose Schedule HC with your return.

If you (and your spouse if married filing jointly) answered **Yes** on both lines 8a and 8b, go to line 9.

If you are filing a joint return and one spouse answers **No** to line 8b but the other spouse answers **Yes** to line 8b, the spouse who answered **No** is not subject to a penalty and should skip the remainder of Schedule HC. The spouse who answered **Yes** must go to line 9.

Line 9. Certificate of Exemption

The Commonwealth Health Insurance Connector Authority provided certificates of exemption to qualified taxpayers who applied in 2012.

- If you have a "**Certificate of Exemption**" issued by the Commonwealth Health Insurance Connector Authority for the 2012 tax year, a penalty does not apply to you. Fill in the **Yes** oval(s) in line 9 of Schedule HC and enter the certificate number in the space provided. **Note:** Only enter the **numbers** of the Certificate of Exemption. Do **not** enter letters, spaces or dashes. For example, if the certificate number on your Certificate of Exemption is AMLI123456-78, enter in the spaces provided 12345678. If married filing jointly and both spouses have a certificate, each spouse must enter their certificate number in the space provided. Skip the remainder of Schedule HC and continue completing your tax return. Be sure to enclose Schedule HC with your return.
- If you answered **No** to line 9, go to line 10.
- If you are filing a joint return and one spouse answers **Yes** to line 9 but the other spouse answers **No** to line 9, the spouse who answered **Yes** must enter the certificate number and skip the remainder of Schedule HC and the spouse who answered **No** must go to line 10.

For more information about Certificates of Exemption, visit the Commonwealth Health Insurance Connector Authority's website at www.mahealthconnector.org.

Lines 10, 11 and 12. Affordability As Determined By State Guidelines

Taxpayers who had four or more consecutive months without health insurance that met Minimum Creditable Coverage in 2012 may be subject to a penalty if they had access to affordable health insurance that met MCC requirements.

If you answered Yes in line 6 of Schedule HC indicating that your income was at or below 150% of the Federal Poverty Level, or

If you had three or fewer blank ovals in a row as shown in line 7,

you are not subject to a penalty and should skip the remainder of Schedule HC and continue completing your tax return. Be sure to enclose Schedule HC with your return.

You must complete the Schedule HC Worksheets for Lines 10, 11 and 12 if you were uninsured for all of 2012 or if you had four or more consecutive months without health insurance (four or more blank ovals in a row in the Months Covered by Health Insurance That Met Minimum Creditable Coverage section of line 7).

To complete these worksheets, you will need to have your completed 2012 U.S. Form 1040, 1040A or 1040EZ. You also will need to know how much it would have cost you to enroll in any health insurance plan offered by an employer in 2012. An employer's Human Resources Department should be able to provide this amount to you.

Filing an Appeal

If you are subject to a penalty for not obtaining health insurance in 2012, you have the right to appeal. The appeal will be heard by the Commonwealth Health Insurance Connector Authority, an independent state body.

In your appeal, you may claim that the penalty should not apply to you. You may claim that you could not afford insurance in 2012 because you experienced a hardship. To establish a hardship, you must be able to show that, during 2012:

(a) You were homeless, more than 30 days in arrears in rent or mortgage payments, or received an eviction or foreclosure notice;

(b) You received a shut-off notice, were shut off, or were refused the delivery of essential utilities (gas, electric, oil, water, or telephone);

(c) You incurred a significant, unexpected increase in essential expenses resulting directly from the consequences of: (i) domestic violence; (ii) the death of a spouse, family member, or partner with primary responsibility for child care, where that spouse, family member, or partner shared household expenses with you; (iii) the sudden responsibility for providing full care for yourself, an aging parent or other family member, including a major, extended illness of a child that required a working parent to hire a full-time caretaker for the child; or (iv) a fire, flood, natural disaster, or other unexpected natural or human-caused event causing substantial household or personal damage for the individual filing the appeal.

(d) Your financial circumstances were such that the expense of purchasing health insurance would have caused you to experience a serious deprivation of food, shelter, clothing or other necessities.

(e) Your family size was so large that reliance on the affordability schedule (see Table 3: Affordability) to determine how much you could afford to pay for health insurance is inequitable.

(f) During 2012 you purchased health insurance that did not meet Minimum Creditable Coverage requirements, but which was close to or substantially met those requirements, and you felt that your circumstances prevented you from buying other insurance that met the requirements.

(g) During 2012 you purchased health insurance that did not meet Minimum Creditable Coverage requirements because that is all that your employer offered, and you felt that your circumstances prevented you from buying other insurance that met the requirements.

You may also base your appeal on other circumstances, such as the application of the affordability tables in Schedule HC to you is inequitable (for example, due to fluctuations in income or other changes in life circumstances that affect financial status during the year), you were unable to obtain government-subsidized insurance despite your income, or other circumstances that made you unable to purchase insurance despite your income.

If you file an appeal, you will be required to state your grounds for appealing, and provide further information and supporting documentation. Any statements and claims you make will be under pains and penalties of perjury.

How to Appeal

To appeal, you must fill in the oval for you (and your spouse, if applicable) on Schedule HC, Appeals Section that authorizes DOR to share information in your tax return, including Schedule HC, with the Commonwealth Health Insurance Connector Authority, the independent state body that will hear the appeal. No penalty will be assessed by DOR pending the outcome of your appeal.

Note: If you are filing an appeal, make sure you have calculated the penalty amount that you are appealing, but do not assess yourself or enter a penalty amount on your income tax return.

If you (and/or your spouse, if married filing jointly) fill in that oval on your return, you will receive a follow-up letter from the Connector Authority asking you to state your grounds for appeal in writing, and submit supporting documentation. **Failure to respond to that form within the time specified will lead to dismissal of your appeal. Also, you (and/or your spouse, if married filing jointly) are allowed only one opportunity to appeal.** The Connector Authority will then review the information you provided. You may be required to participate in a hearing on your case. You will be required to state your claims under pains and penalties of perjury.

Note: Do not include any hardship documentation with your original return. You will be required to submit substantiating hardship documentation at a later date during the appeal process.

2012
Schedule HC Worksheets and Tables

Below are the necessary worksheets you may need to complete your 2012 Schedule HC. Retain these worksheets for your records. Do not submit these with your tax return.

Schedule HC Worksheet for Line 6: Federal Poverty Level

1. Enter your federal adjusted gross income from Schedule HC, line 2 **1** _____

2. Enter the income amount that corresponds to your family size (as entered on Schedule HC, line 1c) from the 150% FPL column from Table 1 . . . . . **2** _____

If line 1 is less than or equal to line 2, your income in 2012 was at or below 150% of the Federal Poverty Level and the penalty does not apply to you in 2012. Fill in the Yes oval in line 6 of Schedule HC, skip the remainder of Schedule HC and continue completing your tax return.

If line 1 is greater than line 2, your income in 2012 was above 150% of the Federal Poverty Level. Fill in the No oval in line 6 of Schedule HC and go to line 7 of Schedule HC.

Schedule HC Worksheet for Line 10: Eligibility for Employer-Sponsored Insurance That Met Minimum Creditable Coverage

The following worksheet will determine if you could have afforded employer-sponsored health insurance that met Minimum Creditable Coverage in 2012 (the employer's Human Resources Department should be able to provide this information to you). Complete only if you (and/or your spouse if married filing jointly) were eligible for insurance that met Minimum Creditable Coverage offered by an employer for the entire period you were uninsured in 2012 that covered you, and your spouse and dependent children, if any. If an employer did not offer health insurance that met Minimum Creditable Coverage that covered you, and your spouse and dependent children, if any, or if you were not eligible for insurance that met Minimum Creditable Coverage offered by an employer, you were self-employed or you were unemployed, fill in the No oval(s) in line 10 of Schedule HC and complete the Schedule HC Worksheet for Line 11 on page HC-7.

Table 1: Federal Poverty Level, Annual Income Standards

Family size*	150% FPL
1	$16,764
2	$22,704
3	$28,644
4	$34,584
5	$40,524
6	$46,464
7	$52,404
8	$58,344
additional	+$ 5,940

***This schedule reflects the Federal Poverty Level standards for 2012.**

Note: If you answered Yes in line 6 of Schedule HC indicating that your income was at or below 150% of the Federal Poverty Level or you had three or fewer blank ovals in a row during the period that the mandate applied on line 7 of Schedule HC, the penalty does not apply to you. Do not complete this worksheet. Skip the remainder of Schedule HC and continue completing your return. Be sure to enclose Schedule HC with your return.

If an employer offered you free health insurance coverage in 2012 that met Minimum Creditable Coverage (the employer's Human Resources Department should be able to provide this information to you), you are deemed able to afford health insurance and are subject to a penalty. Fill in the Yes oval(s) in line 10 of Schedule HC and go to the Health Care Penalty Worksheet on page HC-9.

1. Enter your federal adjusted gross income from U.S. Form 1040, line 37; Form 1040A, line 21; or 1040EZ, line 4 . . . . . **1** _____

If line 1 is less than or equal to: $16,764 if single or married filing separately with no dependents; $22,704 if married filing jointly with no dependents or head of household/married filing separately with one dependent; or $28,644 if married filing jointly with one or more dependents or head of household/married filing separately with two or more dependents, you are deemed unable to afford employer-sponsored health insurance that met Minimum Creditable Coverage requiring an employee contribution. Fill in the No oval(s) in line 10 of Schedule HC. Skip the remainder of this worksheet and go to the Schedule HC Worksheet for Line 11 on page HC-7.

If line 1 is more than: $56,273 if single or married filing separately with no dependents; $89,032 if married filing jointly with no dependents or head of household/married filing separately with one dependent; or $119,270 if married filing jointly with one or more dependents or head of household/married filing separately with two or more dependents, you are deemed able to afford employer-sponsored health insurance that met Minimum Creditable Coverage and are subject to a penalty. Fill in the Yes oval(s) in line 10 of Schedule HC and go to the Health Care Penalty Worksheet on page HC-9.

If line 1 is more than: $16,764 but less than or equal to $56,273 if single or married filing separately with no dependents; $22,704 but less than or equal to $89,032 if married filing jointly with no dependents or head of household/married filing separately with one dependent; or $28,644 but less than or equal to $119,270 if married filing jointly with one or more dependents or head of household/married filing separately with two or more dependents, **go to line 2.**

2. Enter the monthly premium that corresponds with your income range (from line 1 of worksheet) and filing status from Table 3: Affordability on page HC-8. To find this amount, look at the row for your income range in col. a of the appropriate table based on your filing status and go to col. b to find the monthly premium amount . . . . . **2** _____

3. Enter the lowest monthly premium cost of health insurance that would cover you, and your spouse and dependent children, if any, offered to you during your uninsured period in 2012 through an employer. The employer's Human Resources Department should be able to provide this amount to you . . . . . **3** _____

Note: If you declined employer-sponsored health insurance that met Minimum Creditable Coverage, the monthly premium amount may be found on the Health Insurance Responsibility Disclosure Form (HIRD) you should have received from your employer.

If line 3 is less than or equal to line 2: you are deemed able to afford employer-sponsored health insurance that met Minimum Creditable Coverage during your uninsured period(s), which you did not obtain, and you are subject to a penalty. Fill in the Yes oval(s) in line 10 of Schedule HC, and go to the Health Care Penalty Worksheet on page HC-9.

If line 3 is greater than line 2: you could not afford health insurance that met Minimum Creditable Coverage offered to you by your employer, fill in the No oval(s) in line 10 of Schedule HC, and complete the following Schedule HC Worksheet for Line 11 on page HC-7.

Schedule HC Worksheet for Line 11: Eligibility for Government-Subsidized Health Insurance

The following worksheet will determine if you were eligible for government-subsidized health insurance in 2012. Complete the following worksheet only if an employer did not offer you affordable health insurance that met Minimum Creditable Coverage requirements, as determined in the Schedule HC Worksheet for Line 10.

Note: If you answered Yes in line 6 of Schedule HC indicating that your income was at or below 150% of the Federal Poverty Level or you had three or fewer blank ovals in a row during the period that the mandate applied on line 7 of Schedule HC, the penalty does not apply to you. Do not complete this worksheet. Skip the remainder of Schedule HC and continue completing your return.

If married filing separately and living in the same household, each spouse must combine their income figures from their separate U.S. returns when completing this worksheet. Also, same-sex spouses filing a Massachusetts joint return or married filing separately and living in the same household must combine their income figures from their separate U.S. returns when completing this worksheet.

1. Enter your income before adjustments (from U.S. Form 1040, line 22, Form 1040A, line 15 or Form 1040EZ, line 4) ..... **1** _____

2. Enter the amount from the Income column, based on your family size (do not include dependent children age 19 or older in your family size), from Table 2 ..... **2** _____

If line 1 is greater than line 2: you were ineligible for government-subsidized health insurance in 2012 and must fill in the No oval(s) in line 11 of Schedule HC, and go to Schedule HC Worksheet for Line 12 to determine if you were deemed able to afford private health insurance.

If line 1 is less than or equal to line 2, and at any point during the period when you were uninsured: you were not a citizen or an alien legally residing in the U.S., or an employer offered to pay more than 20% of a family plan or 33% of an individual plan (the employer's Human Resources Department should be able to provide this information to you), or you applied for MassHealth or Commonwealth Care and were denied because you were ineligible for services, **you are deemed ineligible for government-subsidized health insurance in 2012.** Fill in the No oval(s) in line 11 of Schedule HC, and go to Schedule HC Worksheet for Line 12 to determine if you were able to afford private health insurance. **Note:** Prior to May 1, 2012, most legal permanent residents who lived in the United States for fewer than five years were not eligible for coverage through the Commonwealth Care program. If you were an Alien With Special Status (AWSS) and uninsured before May, fill in the No oval(s) in line 11 of Schedule HC, and go to Schedule HC Worksheet for Line 12 to determine if you were able to afford private health insurance.

Table 2: Income at 300% of the Federal Poverty Level

Family size*	Income
1	$ 33,516
2	$ 45,396
3	$ 57,276
4	$ 69,156
5	$ 81,036
6	$ 92,916
7	$104,796
8	$116,676
9	$128,556
10	$140,436
11	$152,316
12	$164,196
13	$176,076

***Include only yourself, your spouse (if married filing a joint return) and any dependent children age 18 or younger in your family size. For family size over 13, add $11,880 for each additional family member.**

If line 1 is less than or equal to line 2, and none of the above conditions apply, you would have been deemed eligible for government-subsidized health insurance in 2012, which you did not obtain and you are subject to a penalty. Fill in the Yes oval(s) in line 11 of Schedule HC and go to the Health Care Penalty Worksheet on page HC-9. **Note:** If you believe that, during the period when you were uninsured, your income was actually too high to qualify for government-subsidized insurance, you may have grounds to appeal the penalty. Fill in the Yes oval(s) in line 11 of Schedule HC and go to the instructions for the Appeals section.

Schedule HC Worksheet for Line 12: Ability to Purchase Affordable Private Health Insurance That Met Minimum Creditable Coverage

The following worksheet will determine if you could have purchased affordable private health insurance that met Minimum Creditable Coverage in 2012. Complete the following worksheet only if you (and/or your spouse if married filing jointly) were deemed ineligible for government-subsidized health insurance, as determined in the Schedule HC Worksheet for line 11.

Note: If you answered Yes in line 6 of Schedule HC indicating that your income was at or below 150% of the Federal Poverty Level or you had three or fewer blank ovals in a row during the period that the mandate applied in line 7 of Schedule HC, the penalty does not apply to you. Do not complete this worksheet. Skip the remainder of Schedule HC and continue completing your return. Be sure to enclose Schedule HC with your return.

1. Enter your federal adjusted gross income from U.S. Form 1040, line 37; Form 1040A, line 21; or 1040EZ, line 4 ..... **1** _____

2. Enter the monthly premium that corresponds with your county of residency, age (if married filing a joint return, use the age of the older spouse) and filing status from Table 4: Premiums on page HC-8 ..... **2** _____

Go to the table that corresponds to your county of residency and go to the row for your age range and then go to the column based on your filing status to find the monthly premium amount.

3. Enter the monthly premium that corresponds with your income range (from line 1 of worksheet) and filing status from Table 3: Affordability on page HC-8. To find this amount, look at the row for your income range in col. a of the appropriate table based on your filing status and go to col. b to find the monthly premium amount ..... **3** _____

If line 2 is greater than line 3: you are deemed unable to afford health insurance that met Minimum Creditable Coverage and not subject to a penalty, and you must fill in the No oval(s) in line 12 of Schedule HC and skip the remainder of Schedule HC and continue completing your tax return.

If line 2 is less than or equal to line 3, and at any point during the period when you were uninsured: you were 27 years or older and were offered insurance that met Minimum Creditable Coverage through an employer, or you were 18–26 years old and were offered insurance from an employer towards which the employer paid 33% or more of the total premium (the employer's Human Resources Department should be able to provide this information to you), **you are deemed ineligible to purchase private health insurance in 2012.** Fill in the No oval(s) in line 12 of Schedule HC and skip the remainder of Schedule HC and continue completing your tax return. Be sure to enclose Schedule HC with your tax return.

If line 2 is less than or equal to line 3 and none of the above conditions apply: you are deemed able to afford private health insurance that met Minimum Creditable Coverage, which you did not obtain; you are subject to a penalty and you must fill in the Yes oval(s) in line 12 of Schedule HC and go to the Health Care Penalty Worksheet on page HC-9.

Table 3: Affordability

Individual or Married Filing Separately (no dependents)

a. Federal adjusted gross income		b. Monthly premium
From	To	
$ 0	$16,764	$ 0
$16,765	$22,344	$ 40
$22,345	$27,936	$ 78
$27,937	$33,516	$118
$33,517	$40,195	$178
$40,196	$45,554	$239
$45,555	$56,273	$359
$56,274	Any individual with an annual income over $56,273 is deemed to be able to afford health insurance.	

Married Filing Jointly with no dependents or Head of Household/ Married Filing Separately with one dependent

a. Federal adjusted gross income		b. Monthly premium
From	To	
$ 0	$22,704	$ 0
$22,705	$30,264	$ 80
$30,265	$37,836	$156
$37,837	$45,396	$236
$45,397	$56,656	$320
$56,657	$67,448	$428
$67,449	$89,032	$598
$89,033	Any couple with an annual income over $89,032 is deemed to be able to afford health insurance.	

Married Filing Jointly with one or more dependents or Head of Household/Married Filing Separately with two or more dependents

a. Federal adjusted gross income		b. Monthly premium
From	To	
$ 0	$ 28,644	$ 0
$28,645	$ 38,184	$ 80
$38,185	$ 47,736	$156
$47,737	$ 57,276	$236
$57,277	$ 75,899	$379
$75,900	$ 97,584	$595
$97,585	$119,270	$862
$119,271	Any family with an annual income over $119,270 is deemed to be able to afford health insurance.	

Table 4: Premiums

Region 1. Berkshire, Franklin and Hampshire Counties

Age	Individual[1]	Married couple[2] (no dependents)	Family[3]
0–26	$162	$324	$ 816
27–29	$254	$508	$ 851
30–34	$259	$518	$ 879
35–39	$285	$570	$ 899
40–44	$313	$626	$ 938
45–49	$364	$728	$1,025
50–54	$461	$922	$1,154
55+	$465	$930	$1,189

Region 2. Bristol, Essex, Hampden, Middlesex, Norfolk, Suffolk and Worcester Counties

Age	Individual[1]	Married couple[2] (no dependents)	Family[3]
0–26	$185	$370	$ 703
27–29	$233	$466	$ 703
30–34	$245	$490	$ 840
35–39	$259	$518	$ 878
40–44	$276	$552	$ 930
45–49	$311	$622	$1,043
50–54	$411	$822	$1,299
55+	$424	$848	$1,314

Region 3. Barnstable, Dukes, Nantucket and Plymouth Counties

Age	Individual[1]	Married couple[2] (no dependents)	Family[3]
0–26	$185	$370	$ 722
27–29	$233	$466	$ 737
30–34	$233	$466	$ 957
35–39	$265	$530	$ 991
40–44	$302	$604	$1,019
45–49	$334	$668	$1,116
50–54	$391	$782	$1,260
55+	$403	$806	$1,292

1. Includes married filing separately (no dependents).
2. Rates for a married couple are based on the combined monthly premium cost of individual plans for each spouse, rather than the cost of a two-person (or self plus spouse) plan.
3. Head of household or married couple with dependent(s).

Health Care Penalty Worksheet

Complete the following worksheet to calculate the penalty. If married filing a joint return and both you and your spouse are subject to a penalty, separate worksheets must be filled out to calculate the separate penalty amounts for you and your spouse, using your married filing jointly income. Each separate penalty amount must then be entered on Form 1, line 34a and line 34b or Form 1-NR/PY, line 39a and line 39b.

Note: If you answered Yes in line 6 of Schedule HC indicating that your income was at or below 150% of the Federal Poverty Level, the penalty does not apply to you. Do not complete this worksheet. Skip the remainder of Schedule HC and continue completing your tax return.

1. Enter your federal adjusted gross income from Schedule HC, line 2 . . . . . **1**

2. Look at Table 5, Annual Income Standards, and enter col. A, B, C or D, based on your family size (from line 1c of Schedule HC) and income (from line 1 above) **2**

3. Based on the column entered in line 2, go to Table 6, Penalties for 2012, to determine the monthly penalty amount. Enter that amount here. If you entered col. D, enter the penalty amount that corresponds to your age **3**

4. Enter the number of gap(s) in coverage of four or more consecutive months in which you were uninsured, as shown in Schedule HC, line 7. **(Turning 18, Part-Year Residents or a Taxpayer Was Deceased:** When completing line 4, do not include the number of unfilled ovals for months that the mandate did not apply, as determined in Schedule HC, line 7.) If you were uninsured for all of 2012 or for the period that the mandate applied, enter "0". **4**

5. Enter the total number of months for the gap(s) in coverage in which you were uninsured from line 4. If you were uninsured for all of 2012, enter "12" **5**

6. Multiply line 4 by the number "3" **6**

7. Subtract line 6 from line 5 . . . . . **7**

8. Multiply line 3 by line 7. This is your penalty amount **8**

If you are subject to a penalty because you are deemed able to afford insurance in 2012 but did not obtain it, you may appeal the application of the penalty to you. Instructions for filing an appeal can be found online at www.mass.gov/dor. If you are filing an appeal, do not enter a penalty amount on Form 1, line 34a or line 34b or Form 1-NR/PY, line 39a or line 39b. If you are not appealing the penalty, enter the penalty amount from line 8 on Form 1, line 34a or line 34b or Form 1-NR/PY, line 39a or line 39b.

Table 5: Annual Income Standards

Family size	Col. A		Col. B		Col. C		Col. D
	From	To	From	To	From	To	Above
1	$16,765	– $22,344	$22,345	– $27,936	$27,937	– $33,516	$33,516
2	22,705	– 30,264	30,265	– 37,836	37,837	– 45,396	45,396
3	28,645	– 38,184	38,185	– 47,736	47,737	– 57,276	57,276
4	34,585	– 46,104	46,105	– 57,636	57,637	– 69,156	69,156
5	40,525	– 54,024	54,025	– 67,536	67,537	– 81,036	81,036
6	46,465	– 61,944	61,945	– 77,436	77,437	– 92,916	92,916
7	52,405	– 69,864	69,865	– 87,336	87,337	– 104,796	104,796
8	58,345	– 77,784	77,785	– 97,236	97,237	– 116,676	116,676
additional	+ $ 5,940	+ $ 7,920	+ $ 7,920	+ $ 9,900	+ $ 9,900	+ $11,880	+ $11,880

Table 6: Penalties for 2012

Col.	Monthly penalty amount
A	$19.00
B	$38.00
C	$58.00
D-1 (age 18–26)*	$83.00
D-2 (age 27+)*	$105.00

*If you turned 27 during 2012, use col. D-1 (age 18-26) amount in line 3 of the Health Care Penalty Worksheet.

Municipality	County
Abington	Plymouth
Acton	Middlesex
Acushnet	Bristol
Adams	Berkshire
Agawam	Hampden
Alford	Berkshire
Amesbury	Essex
Amherst	Hampshire
Andover	Essex
Arlington	Middlesex
Ashburnham	Worcester
Ashby	Middlesex
Ashfield	Franklin
Ashland	Middlesex
Athol	Worcester
Attleboro	Bristol
Auburn	Worcester
Avon	Norfolk
Ayer	Middlesex
Barnstable	Barnstable
Barre	Worcester
Becket	Berkshire
Bedford	Middlesex
Belchertown	Hampshire
Bellingham	Norfolk
Belmont	Middlesex
Berkley	Bristol
Berlin	Worcester
Bernardston	Franklin
Beverly	Essex
Billerica	Middlesex
Blackstone	Worcester
Blandford	Hampden
Bolton	Worcester
Boston	Suffolk
Bourne	Barnstable
Boxborough	Middlesex
Boxford	Essex
Boylston	Worcester
Braintree	Norfolk
Brewster	Barnstable
Bridgewater	Plymouth
Brimfield	Hampden
Brockton	Plymouth
Brookfield	Worcester
Brookline	Norfolk
Buckland	Franklin
Burlington	Middlesex
Cambridge	Middlesex
Canton	Norfolk
Carlisle	Middlesex
Carver	Plymouth
Charlemont	Franklin
Charlton	Worcester
Chatham	Barnstable
Chelmsford	Middlesex
Chelsea	Suffolk
Cheshire	Berkshire
Chester	Hampden
Chesterfield	Hampshire
Chicopee	Hampden
Chilmark	Dukes
Clarksburg	Berkshire
Clinton	Worcester
Cohasset	Norfolk
Colrain	Franklin
Concord	Middlesex
Conway	Franklin
Cummington	Hampshire
Dalton	Berkshire
Danvers	Essex
Dartmouth	Bristol
Dedham	Norfolk
Deerfield	Franklin
Dennis	Barnstable
Dighton	Bristol
Douglas	Worcester
Dover	Norfolk
Dracut	Middlesex
Dudley	Worcester
Dunstable	Middlesex
Duxbury	Plymouth
East Bridgewater	Plymouth
East Brookfield	Worcester
East Longmeadow	Hampden
Eastham	Barnstable
Easthampton	Hampshire
Easton	Bristol
Edgartown	Dukes
Egremont	Berkshire
Erving	Franklin
Essex	Essex
Everett	Middlesex
Fairhaven	Bristol
Fall River	Bristol
Falmouth	Barnstable
Fitchburg	Worcester
Florida	Berkshire
Foxborough	Norfolk
Framingham	Middlesex
Franklin	Norfolk
Freetown	Bristol
Gardner	Worcester
Gay Head	Dukes
Georgetown	Essex
Gill	Franklin
Gloucester	Essex
Goshen	Hampshire
Gosnold	Dukes
Grafton	Worcester
Granby	Hampshire
Granville	Hampden
Great Barrington	Berkshire
Greenfield	Franklin
Groton	Middlesex
Groveland	Essex
Hadley	Hampshire
Halifax	Plymouth
Hamilton	Essex
Hampden	Hampden
Hancock	Berkshire
Hanover	Plymouth
Hanson	Plymouth
Hardwick	Worcester
Harvard	Worcester
Harwich	Barnstable
Hatfield	Hampshire
Haverhill	Essex
Hawley	Franklin
Heath	Franklin
Hingham	Plymouth
Hinsdale	Berkshire
Holbrook	Norfolk
Holden	Worcester
Holland	Hampden
Holliston	Middlesex
Holyoke	Hampden
Hopedale	Worcester
Hopkinton	Middlesex
Hubbardston	Worcester
Hudson	Middlesex
Hull	Plymouth
Huntington	Hampshire
Ipswich	Essex
Kingston	Plymouth
Lakeville	Plymouth
Lancaster	Worcester
Lanesborough	Berkshire
Lawrence	Essex
Lee	Berkshire
Leicester	Worcester
Lenox	Berkshire
Leominster	Worcester
Leverett	Franklin
Lexington	Middlesex
Leyden	Franklin
Lincoln	Middlesex
Littleton	Middlesex
Longmeadow	Hampden
Lowell	Middlesex
Ludlow	Hampden
Lunenburg	Worcester
Lynn	Essex
Lynnfield	Essex
Malden	Middlesex
Manchester	Essex
Mansfield	Bristol
Marblehead	Essex
Marion	Plymouth
Marlborough	Middlesex
Marshfield	Plymouth
Mashpee	Barnstable
Mattapoisett	Plymouth
Maynard	Middlesex
Medfield	Norfolk
Medford	Middlesex
Medway	Norfolk
Melrose	Middlesex
Mendon	Worcester
Merrimac	Essex
Methuen	Essex
Middleborough	Plymouth
Middlefield	Hampshire
Middleton	Essex
Milford	Worcester
Millbury	Worcester
Millis	Norfolk
Millville	Worcester
Milton	Norfolk
Monroe	Franklin
Monson	Hampden
Montague	Franklin
Monterey	Berkshire
Montgomery	Hampden
Mount Washington	Berkshire
Nahant	Essex
Nantucket	Nantucket
Natick	Middlesex
Needham	Norfolk
New Ashford	Berkshire
New Bedford	Bristol
New Braintree	Worcester
New Marlborough	Berkshire
New Salem	Franklin
Newbury	Essex
Newburyport	Essex
Newton	Middlesex
Norfolk	Norfolk
North Adams	Berkshire
North Andover	Essex
North Attleborough	Bristol
North Brookfield	Worcester
North Reading	Middlesex
Northampton	Hampshire
Northborough	Worcester
Northbridge	Worcester
Northfield	Franklin
Norton	Bristol
Norwell	Plymouth
Norwood	Norfolk
Oak Bluffs	Dukes
Oakham	Worcester
Orange	Franklin
Orleans	Barnstable
Otis	Berkshire
Oxford	Worcester
Palmer	Hampden
Paxton	Worcester
Peabody	Essex
Pelham	Hampshire
Pembroke	Plymouth
Pepperell	Middlesex
Peru	Berkshire
Petersham	Worcester
Phillipston	Worcester
Pittsfield	Berkshire
Plainfield	Hampshire
Plainville	Norfolk
Plymouth	Plymouth
Plympton	Plymouth
Princeton	Worcester
Provincetown	Barnstable
Quincy	Norfolk
Randolph	Norfolk
Raynham	Bristol
Reading	Middlesex
Rehoboth	Bristol
Revere	Suffolk
Richmond	Berkshire
Rochester	Plymouth
Rockland	Plymouth
Rockport	Essex
Rowe	Franklin
Rowley	Essex
Royalston	Worcester
Russell	Hampden
Rutland	Worcester
Salem	Essex
Salisbury	Essex
Sandisfield	Berkshire
Sandwich	Barnstable
Saugus	Essex
Savoy	Berkshire
Scituate	Plymouth
Seekonk	Bristol
Sharon	Norfolk
Sheffield	Berkshire
Shelburne	Franklin
Sherborn	Middlesex
Shirley	Middlesex
Shrewsbury	Worcester
Shutesbury	Franklin
Somerset	Bristol
Somerville	Middlesex
South Hadley	Hampshire
Southampton	Hampshire
Southborough	Worcester
Southbridge	Worcester
Southwick	Hampden
Spencer	Worcester
Springfield	Hampden
Sterling	Worcester
Stockbridge	Berkshire
Stoneham	Middlesex
Stoughton	Norfolk
Stow	Middlesex
Sturbridge	Worcester
Sudbury	Middlesex
Sunderland	Franklin
Sutton	Worcester
Swampscott	Essex
Swansea	Bristol
Taunton	Bristol
Templeton	Worcester
Tewksbury	Middlesex
Tisbury	Dukes
Tolland	Hampden
Topsfield	Essex
Townsend	Middlesex
Truro	Barnstable
Tyngsborough	Middlesex
Tyringham	Berkshire
Upton	Worcester
Uxbridge	Worcester
Wakefield	Middlesex
Wales	Hampden
Walpole	Norfolk
Waltham	Middlesex
Ware	Hampshire
Wareham	Plymouth
Warren	Worcester
Warwick	Franklin
Washington	Berkshire
Watertown	Middlesex
Wayland	Middlesex
Webster	Worcester
Wellesley	Norfolk
Wellfleet	Barnstable
Wendell	Franklin
Wenham	Essex
West Boylston	Worcester
West Bridgewater	Plymouth
West Brookfield	Worcester
West Newbury	Essex
West Springfield	Hampden
West Stockbridge	Berkshire
West Tisbury	Dukes
Westborough	Worcester
Westfield	Hampden
Westford	Middlesex
Westhampton	Hampshire
Westminster	Worcester
Weston	Middlesex
Westport	Bristol
Westwood	Norfolk
Weymouth	Norfolk
Whately	Franklin
Whitman	Plymouth
Wilbraham	Hampden
Williamsburg	Hampshire
Williamstown	Berkshire
Wilmington	Middlesex
Winchendon	Worcester
Winchester	Middlesex
Windsor	Berkshire
Winthrop	Suffolk
Woburn	Middlesex
Worcester	Worcester
Worthington	Hampshire
Wrentham	Norfolk
Yarmouth	Barnstable

Appendix 2: List of Procedure Codes Matched Group Received During 2012

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List of Procedure Codes Matched Group Received During 2012 (Duplicate Procedures Removed)
3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality; requiring image postprocessing on an independent workstation
Ablation, 1 or more liver tumor(s), percutaneous, radiofrequency
Acetaminophen
Administration of influenza virus vaccine
Albumin; serum, plasma or whole blood
Albumin; urine, microalbumin, quantitative
Alcohol (ethanol); any specimen except breath
Alpha-fetoprotein (AFP); serum
Amalgam - one surface, primary or permanent
Amalgam - three surfaces, primary or permanent
Amalgam - two surfaces, primary or permanent
Ammonia
Amylase
Antibody screen, RBC, each serum technique
Antibody; Borrelia burgdorferi (Lyme disease)
Antibody; Borrelia burgdorferi (Lyme disease) confirmatory test (eg, Western Blot or immunoblot)
Antibody; Helicobacter pylori
Antibody; HIV-1 and HIV-2, single result
Antibody; mumps
Antibody; parvovirus
Antibody; rubella
Antibody; rubeola
Antibody; varicella-zoster
Antinuclear antibodies (ANA);
Application of a modality to 1 or more areas; ultrasound, each 15 minutes
Application of short arm splint (forearm to hand); static
Application of short leg cast (below knee to toes);
Application of short leg splint (calf to foot)
Arthroscopy, knee, surgical; with meniscectomy (medial OR lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed
Basic metabolic panel (Calcium, ionized) This panel must include the following: Calcium, ionized (82330), Carbon dioxide (82374), Chloride (82435), Creatinine (82565), Glucose (82947), Potassium (84132), Sodium (84295), Urea Nitrogen (BUN) (84520)

Basic metabolic panel (Calcium, total) This panel must include the following: Calcium, total (82310), Carbon dioxide (82374), Chloride (82435), Creatinine (82565), Glucose (82947), Potassium (84132), Sodium (84295), Urea nitrogen (BUN) (84520)
Bilirubin; direct
Bilirubin; total
Biopsy of liver, needle; percutaneous
Bitewing - single film
Bitewings - four films
Blood count; blood smear, microscopic examination with manual differential WBC count
Blood count; blood smear, microscopic examination without manual differential WBC count
Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count)
Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count
Blood count; hemoglobin (Hgb)
Blood count; leukocyte (WBC), automated
Blood count; platelet, automated
Blood count; red blood cell (RBC), automated
Blood count; reticulocyte, automated
Blood typing; ABO
Blood typing; Rh (D)
Blood, occult, by fecal hemoglobin determination by immunoassay, qualitative, feces, 1-3 simultaneous determinations
Blood, occult, by peroxidase activity (eg, guaiac), qualitative, feces, 1-3 simultaneous determinations, performed for other than colorectal neoplasm screening
Blood, occult, by peroxidase activity (eg, guaiac), qualitative; feces, consecutive collected specimens with single determination, for colorectal neoplasm screening (ie, patient was provided 3 cards or single triple card for consecutive collection)
Calcium; ionized
Calcium; total
Carbon dioxide (bicarbonate)
Carcinoembryonic antigen (CEA)
Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; tracing only, without interpretation and report
Case presentation, detailed and extensive treatment planning
Cell count, miscellaneous body fluids (eg, cerebrospinal fluid, joint fluid), except blood; with differential count
Cervical or vaginal cancer screening; pelvic and clinical breast examination
Chloride; blood
Cholesterol, serum or whole blood, total
Closed treatment of interphalangeal joint dislocation, single, with manipulation; without anesthesia

Closed treatment of metacarpal fracture, single; without manipulation, each bone
Collection of capillary blood specimen (eg, finger, heel, ear stick)
Collection of venous blood by venipuncture
Colonoscopy, flexible, proximal to splenic flexure; with biopsy, single or multiple
Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk
Colposcopy of the cervix including upper/adjacent vagina; with biopsy(s) of the cervix and endocervical curettage
Comprehensive metabolic panel This panel must include the following: Albumin (82040), Bilirubin, total (82247), Calcium, total (82310), Carbon dioxide (bicarbonate) (82374), Chloride (82435), Creatinine (82565), Glucose (82947), Phosphatase, alkaline (840
Comprehensive oral evaluation – new or established patient
Comprehensive Periodontal Evaluation
Computed tomographic angiography, chest (noncoronary), with contrast material(s), including noncontrast images, if performed, and image postprocessing
Computed tomography guidance for, and monitoring of, parenchymal tissue ablation
Computed tomography, abdomen and pelvis; with contrast material(s)
Computed tomography, abdomen and pelvis; without contrast material
Computed tomography, cervical spine; without contrast material
Computed tomography, head or brain; with contrast material(s)
Computed tomography, head or brain; without contrast material
Computed tomography, lower extremity; without contrast material
Computed tomography, maxillofacial area; without contrast material
Computed tomography, soft tissue neck; with contrast material(s)
Computer-aided detection (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation, with or without digitization of film radiographic images; diagnostic mammography
Computer-aided detection (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation, with or without digitization of film radiographic images; screening mammography
Concentration (any type), for infectious agents
Contraceptive pills for birth control
Control nasal hemorrhage, anterior, simple (limited cautery and/or packing) any method
C-reactive protein;
Creatine kinase (CK), (CPK); MB fraction only
Creatine kinase (CK), (CPK); total
Creatinine; blood
Creatinine; other source
Culture, bacterial; aerobic isolate, additional methods required for definitive identification, each isolate
Culture, bacterial; anaerobic isolate, additional methods required for definitive identification, each isolate

Culture, bacterial; any other source except urine, blood or stool, aerobic, with isolation and presumptive identification of isolates
Culture, bacterial; any source, except blood, anaerobic with isolation and presumptive identification of isolates
Culture, bacterial; blood, aerobic, with isolation and presumptive identification of isolates (includes anaerobic culture, if appropriate)
Culture, bacterial; quantitative colony count, urine
Culture, bacterial; quantitative, aerobic with isolation and presumptive identification of isolates, any source except urine, blood or stool
Culture, bacterial; with isolation and presumptive identification of each isolate, urine
Culture, presumptive, pathogenic organisms, screening only;
Cyanocobalamin (Vitamin B-12);
Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; manual screening under physician supervision
Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; with screening by automated system and manual rescreening or review, under physician supervision
Cytopathology, cervical or vaginal (any reporting system), requiring interpretation by physician
Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy for diagnosis, first evaluation episode, each site
Cytopathology, evaluation of fine needle aspirate; interpretation and report
Demonstration and/or evaluation of patient utilization of an aerosol generator, nebulizer, metered dose inhaler or IPPB device
Deoxyribonucleic acid (DNA) antibody; single stranded
Determination of refractive state
Dexamethasone, oral, 0.25 mg
Diagnostic mammography, producing direct digital image, bilateral, all views
Diagnostic mammography, producing direct digital image, unilateral, all views
Dipropylacetic acid (valproic acid)
Drainage of abscess, cyst, hematoma from dentoalveolar structures
Dressings and/or debridement of partial-thickness burns, initial or subsequent; small (less than 5% total body surface area)
Drug screen, other than chromatographic; any number of drug classes, by CLIA waived test or moderate complexity test, per patient encounter
Drug screen, qualitative; multiple drug classes by high complexity test method (e.g., immunoassay, enzyme assay), per patient encounter
Drug screen, qualitative; single drug class method (eg, immunoassay, enzyme assay), each drug class
Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs; complete study
Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs; limited study
Duplex scan of extremity veins including responses to compression and other maneuvers; complete bilateral study

Duplex scan of extremity veins including responses to compression and other maneuvers; unilateral or limited study
Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, with spectral Doppler echocardiography, and with color flow Doppler echocardiography
Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, follow-up or limited study
Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan of care
Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only
Electrocardiogram, routine ECG with at least 12 leads; tracing only, without interpretation and report
Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report
Electroencephalogram (EEG); including recording awake and asleep
Electrolyte panel This panel must include the following: Carbon dioxide (82374), Chloride (82435), Potassium (84132), Sodium (84295)
Emergency department visit for the evaluation and management of a patient, which requires these 3 key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status: A comprehensive history
Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care
Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A problem focused history; A problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care
Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of low complexity. Counseling and/or coordination of care
Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of moderate complexity. Counseling
External electrocardiographic recording up to 48 hours by continuous rhythm recording and storage; recording (includes connection, recording, and disconnection)
External electrocardiographic recording up to 48 hours by continuous rhythm recording and storage; scanning analysis with report
External patient and, when performed, auto activated electrocardiographic rhythm derived event recording with symptom-related memory loop with remote download capability up to 30 days, 24-hour attended monitoring; recording (includes connection, recording)
Extraction, erupted tooth or exposed root (elevation and/or forceps removal)
Ferritin
Fetal biophysical profile; without non-stress testing
Fibrin degradation products, D-dimer; quantitative
Fitting of spectacles, except for aphakia; bifocal
Fitting of spectacles, except for aphakia; monofocal

Folic acid; serum
Frames, purchases
Gases, blood, any combination of pH, pCO2, pO2, CO2, HCO3 (including calculated O2 saturation); with O2 saturation, by direct measurement, except pulse oximetry
Glucose, blood by glucose monitoring device(s) cleared by the FDA specifically for home use
Glucose, body fluid, other than blood
Glucose; blood, reagent strip
Glucose; quantitative, blood (except reagent strip)
Glutamyltransferase, gamma (GGT)
Gonadotropin, chorionic (hCG); qualitative
Gonadotropin, chorionic (hCG); quantitative
Gonadotropin; follicle stimulating hormone (FSH)
Gonadotropin; luteinizing hormone (LH)
Group psychotherapy (other than of a multiple-family group)
Handling and/or conveyance of specimen for transfer from the physician's office to a laboratory
Haptoglobin; quantitative
Hemoglobin; glycosylated (A1C)
Hepatic function panel This panel must include the following: Albumin (82040), Bilirubin, total (82247), Bilirubin, direct (82248), Phosphatase, alkaline (84075), Protein, total (84155), Transferase, alanine amino (ALT) (SGPT) (84460), Transferase, aspart
Hepatitis A antibody (HAAb); total
Hepatitis B core antibody (HBcAb); total
Hepatitis B surface antibody (HBsAb)
Hepatitis B vaccine, pediatric/adolescent dosage (3 dose schedule), for intramuscular use
Hepatitis C antibody;
Heterophile antibodies; screening
Hospital observation service, per hour
Human Papilloma virus (HPV) vaccine, types 6, 11, 16, 18 (quadrivalent), 3 dose schedule, for intramuscular use
Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid)
Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)
Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid administered
Immunoassay for infectious agent antibody, quantitative, not otherwise specified
Immunohistochemistry (including tissue immunoperoxidase), each antibody
Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); complicated or multiple
Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); simple or single

Incision and drainage of ischiorectal and/or perirectal abscess (separate procedure)
Incision and drainage, perianal abscess, superficial
Incision and removal of foreign body, subcutaneous tissues; simple
Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient;
Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient;
Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; hepatitis B surface antigen (HBsAg)
Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; Influenza, A or B, each
Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; Streptococcus, group A
Infectious agent antigen detection by immunoassay with direct optical observation; Streptococcus, group A
Infectious agent detection by nucleic acid (DNA or RNA), not otherwise specified; amplified probe technique, each organism
Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia trachomatis, amplified probe technique
Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia trachomatis, direct probe technique
Infectious agent detection by nucleic acid (DNA or RNA); Neisseria gonorrhoeae, amplified probe technique
Infectious agent detection by nucleic acid (DNA or RNA); Neisseria gonorrhoeae, direct probe technique
Infectious agent detection by nucleic acid (DNA or RNA); papillomavirus, human, amplified probe technique
Infectious agent detection by nucleic acid (DNA or RNA); Staphylococcus aureus, methicillin resistant, amplified probe technique
Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use
Infusion, normal saline solution, 1,000 cc
Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnosis
Initial observation care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination
Injection procedure for shoulder arthrography or enhanced CT/MRI shoulder arthrography
Injection, ampicillin sodium/sulbactam sodium, per 1.5 g
Injection, cefazolin sodium, 500 mg
Injection, ceftriaxone sodium, per 250 mg
Injection, clindamycin phosphate, 300 mg
Injection, dexamethasone sodium phosphate, 1 mg

Injection, diphenhydramine HCl, up to 50 mg
Injection, fentanyl citrate, 0.1 mg
Injection, gadobenate dimeglumine (MultiHance), per ml
Injection, gadolinium-based magnetic resonance contrast agent, not otherwise specified (NOS), per ml
Injection, Heparin sodium, per 1000 units
Injection, hydromorphone, up to 4 mg
Injection, intralesional; up to and including 7 lesions
Injection, ketorolac tromethamine, per 15 mg
Injection, lidocaine HCl for intravenous infusion, 10 mg
Injection, lorazepam, 2 mg
Injection, medroxyprogesterone acetate for contraceptive use, 150 mg
Injection, methylergonovine maleate, up to 0.2 mg
Injection, methylprednisolone acetate, 80 mg
Injection, methylprednisolone sodium succinate, up to 125 mg
Injection, metoclopramide HCl, up to 10 mg
Injection, metronidazole, 500 mg
Injection, midazolam HCl, per 1 mg
Injection, morphine sulfate, up to 10 mg
Injection, naloxone HCl, per 1 mg
Injection, neostigmine methylsulfate, up to 0.5 mg
Injection, ondansetron HCl, per 1 mg
Injection, pantoprazole sodium, per vial
Injection, penicillin G benzathine, 100,000 units
Injection, promethazine HCl, up to 50 mg
Injection, ropivacaine HCl, 1 mg
Injection, succinylcholine chloride, up to 20 mg
Injection, triamcinolone acetonide, not otherwise specified, 10 mg
Injection, vancomycin HCl, 500 mg
Insertion of intrauterine device (IUD)
Intraoral – complete series (including bitewings)
Intraoral – periapical, each additional film
Intraoral – periapical, first film
Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); additional sequential infusion of a new drug/substance, up to 1 hour (List separately in addition to code for primary procedure)
Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour
Intravenous infusion, hydration; each additional hour (List separately in addition to code for primary procedure)
Intravenous infusion, hydration; initial, 31 minutes to 1 hour
Introduction of needle or intracatheter, vein

Iron
Iron binding capacity
Lactate (lactic acid)
Lactate dehydrogenase (LD), (LDH);
Laparoscopy, surgical, myomectomy, excision; 5 or more intramural myomas and/or intramural myomas with total weight greater than 250 g
Level 4 hospital emergency department visit provided in a type B emergency department; (the ED must meet at least one of the following requirements: (1) it is licensed by the state in which it is located under applicable state law as an emergency room or . . . .
Level III - Surgical pathology, gross and microscopic examination Abortion, induced, Abscess, Aneurysm - arterial/ventricular, Anus, tag, Appendix, other than incidental, Artery, atheromatous plaque, Bartholin's gland cyst, Bone fragment(s), other than pa . . . .
Level IV - Surgical pathology, gross and microscopic examination Abortion - spontaneous/missed, Artery, biopsy, Bone marrow, biopsy, Bone exostosis, Brain/meninges, other than for tumor resection, Breast, biopsy, not requiring microscopic evaluation of su . . . .
Levonorgestrel-releasing intrauterine contraceptive system, 52 mg
Limited oral evaluation - problem focused (twice per calendar year)
Lipase
Lipid panel This panel must include the following: Cholesterol, serum, total (82465), Lipoprotein, direct measurement, high density cholesterol (HDL cholesterol) (83718), Triglycerides (84478)
Lipoprotein, direct measurement; high density cholesterol (HDL cholesterol)
Lipoprotein, direct measurement; LDL cholesterol
Low osmolar contrast material, 300-399 mg/ml iodine concentration, per ml
Magnesium
Magnetic resonance (eg, proton) imaging, abdomen; without contrast material(s), followed by with contrast material(s) and further sequences
Magnetic resonance (eg, proton) imaging, any joint of upper extremity; with contrast material(s)
Magnetic resonance (eg, proton) imaging, any joint of upper extremity; without contrast material(s)
Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; without contrast material
Magnetic resonance (eg, proton) imaging, upper extremity, other than joint; without contrast material(s), followed by contrast material(s) and further sequences
Mammography; unilateral
Manual therapy techniques (eg, mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes
Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes
Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes
Molecular cytogenetics; DNA probe, each (eg, FISH)
Molecular cytogenetics; interphase in situ hybridization, analyze 25-99 cells

Molecular diagnostics; amplification, signal, each nucleic acid sequence
Molecular diagnostics; amplification, target, multiplex, each additional nucleic acid sequence beyond 2 (List separately in addition to code for primary procedure)
Molecular diagnostics; amplification, target, multiplex, first 2 nucleic acid sequences
Molecular diagnostics; isolation or extraction of highly purified nucleic acid, each nucleic acid type (ie, DNA or RNA)
Molecular diagnostics; lysis of cells prior to nucleic acid extraction (eg, stool specimens, paraffin embedded tissue), each specimen
Molecular diagnostics; molecular isolation or extraction, each nucleic acid type (ie, DNA or RNA)
Morcellator
Noninvasive ear or pulse oximetry for oxygen saturation; multiple determinations (eg, during exercise)
Noninvasive ear or pulse oximetry for oxygen saturation; single determination
Office consultation for a new or established patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies
Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of . . . .
Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity. Counseling and/or coordination . . . .
Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; Medical decision making of low complexity. Counseling and/or coordination of care with . . . .
Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination . . . .
Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; Straightforward medical decision making. Counseling . . . .
Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these . . . .
Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling . . . .
Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/o . . . .
Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling . . . .

Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low
Ondansetron 1 mg, oral, FDA approved prescription antiemetic, for use as a complete therapeutic substitute for an IV antiemetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen . . . .
Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, 1 or more visits
Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; comprehensive, established patient, 1 or more visits
Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient
Oral hygiene instruction
Palliative (emergency) treatment of dental pain - minor procedure
Panoramic film
Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); 2 to 4 lesions
Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diag . . . .
Periodic oral examination
Periodontal scaling and root planing, 4+ teeth, per quadrant
Pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy
Phosphatase, alkaline;
Phosphatase, alkaline; isoenzymes
Phosphorus inorganic (phosphate);
Physical therapy evaluation
Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, when administered to individuals 2 years or older, for subcutaneous or intramuscular use
Potassium; serum, plasma or whole blood
Prednisone, oral, per 5 mg
Pressurized or nonpressurized inhalation treatment for acute airway obstruction or for sputum induction for diagnostic purposes (eg, with an aerosol generator, nebulizer, metered dose inhaler or intermittent positive pressure breathing [IPPB] device)
Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 30 minutes
Procedures and interventions not elsewhere classified
Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with physician analysis, review and report; single lead pacemaker system
Prolactin
Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour (List separately in addition to code for office or other outpatient Evaluation and Management service)

Prophylaxis - adult
Prostate specific antigen (PSA); total
Protein, total, except by refractometry; other source (eg, synovial fluid, cerebrospinal fluid)
Protein, total, except by refractometry; serum, plasma or whole blood
Prothrombin time;
Psychiatric diagnostic interview examination
Pure tone audiometry (threshold); air only
Radiologic examination, abdomen; complete, including decubitus and/or erect views
Radiologic examination, ankle; 2 views
Radiologic examination, ankle; complete, minimum of 3 views
Radiologic examination, chest, 2 views, frontal and lateral;
Radiologic examination, chest, 2 views, frontal and lateral; with oblique projections
Radiologic examination, chest; single view, frontal
Radiologic examination, elbow; complete, minimum of 3 views
Radiologic examination, finger(s), minimum of 2 views
Radiologic examination, foot; complete, minimum of 3 views
Radiologic examination, hand; minimum of 3 views
Radiologic examination, hip, unilateral; complete, minimum of 2 views
Radiologic examination, knee; 3 views
Radiologic examination, pelvis; 1 or 2 views
Radiologic examination, ribs, unilateral; including posteroanterior chest, minimum of 3 views
Radiologic examination, sacrum and coccyx, minimum of 2 views
Radiologic examination, shoulder, arthrography, radiological supervision and interpretation
Radiologic examination, shoulder; complete, minimum of 2 views
Radiologic examination, sinuses, paranasal, complete, minimum of 3 views
Radiologic examination, spine, cervical; complete, including oblique and flexion and/or extension studies
Radiologic examination, spine, cervical; minimum of 4 views
Radiologic examination, spine, lumbosacral; 2 or 3 views
Radiologic examination, spine; thoracic, 3 views
Radiologic examination, wrist; complete, minimum of 3 views
Radiologic examination; forearm, 2 views
Radiologic examination; neck, soft tissue
Radiologic examination; tibia and fibula, 2 views
Radiologic examination; toe(s), minimum of 2 views
Removal of foreign body, external eye; corneal, without slit lamp
Removal of intrauterine device (IUD)
Renal function panel This panel must include the following: Albumin (82040), Calcium, total (82310), Carbon dioxide (bicarbonate) (82374), Chloride (82435), Creatinine (82565), Glucose (82947), Phosphorus inorganic (phosphate) (84100), Potassium (84132),
Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less

Resin-based composite - 4 + srfs/ involve incisal angle (anterior)
Resin-based composite – 4+ surfaces, posterior
Resin-based composite - one surface, anterior
Resin-based composite – one surface, posterior
Resin-based composite - three surfaces, anterior
Resin-based composite – three surfaces, posterior
Resin-based composite - two surfaces, anterior
Resin-based composite – two surfaces, posterior
Rhythm ECG, 1-3 leads; tracing only without interpretation and report
Salicylate
Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, screening by cytotechnologist under physician supervision
Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with screening by automated system and manual rescreening under physician supervision
Screening mammography, bilateral (2-view film study of each breast)
Screening mammography, producing direct digital image, bilateral, all views
Screening Papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory
Screening test of visual acuity, quantitative, bilateral
Screening test, pure tone, air only
Sedimentation rate, erythrocyte; automated
Sedimentation rate, erythrocyte; non-automated
Service(s) provided between 10:00 PM and 8:00 AM at 24-hour facility, in addition to basic service
Service(s) provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service
Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (eg, holidays, Saturday or Sunday), in addition to basic service
Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less
Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.6 cm to 5.0 cm
Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less
Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.6 cm to 7.5 cm
Skin test; tuberculosis, intradermal
Smear, primary source with interpretation; Gram or Giemsa stain for bacteria, fungi, or cell types
Smear, primary source with interpretation; special stain for inclusion bodies or parasites (eg, malaria, coccidia, microsporidia, trypanosomes, herpes viruses)

Smear, primary source with interpretation; wet mount for infectious agents (eg, saline, India ink, KOH preps)
Sodium; serum, plasma or whole blood
Special stain including interpretation and report; Group I for microorganisms (eg, acid fast, methenamine silver)
Sphere, single vision, plano to plus or minus 4.00, per lens
Spherocylinder, bifocal, plano to plus or minus 4.00d sphere, 0.12 to 2.00d cylinder, per lens
Spherocylinder, single vision, plano to plus or minus 4.00d sphere, 0.12 to 2.00d cylinder, per lens
Spinal puncture, lumbar, diagnostic
Strapping; toes
Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Medical decision making that is straightforward or o
Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap& removal of bone and/or section of tooth
Susceptibility studies, antimicrobial agent; enzyme detection (eg, beta lactamase), per enzyme
Susceptibility studies, antimicrobial agent; microdilution or agar dilution (minimum inhibitory concentration [MIC] or breakpoint), each multi-antimicrobial, per plate
Tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap), when administered to individuals 7 years or older, for intramuscular use
Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); each additional sequential intravenous push of a new substance/drug (List separately in addition to code for primary procedure)
Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); each additional sequential intravenous push of the same substance/drug provided in a facility (List separately in addition to code for primary procedure)
Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug
Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular
Thromboplastin time, partial (PTT); plasma or whole blood
Thyroid stimulating hormone (TSH)
Thyroxine; free
Tissue examination by KOH slide of samples from skin, hair, or nails for fungi or ectoparasite ova or mites (eg, scabies)
Transferase; alanine amino (ALT) (SGPT)
Transferase; aspartate amino (AST) (SGOT)
Transferrin
Troponin, quantitative
Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation

Ultrasound, abdominal, real time with image documentation; complete
Ultrasound, abdominal, real time with image documentation; limited (eg, single organ, quadrant, follow-up)
Ultrasound, breast(s) (unilateral or bilateral), real time with image documentation
Ultrasound, chest (includes mediastinum), real time with image documentation
Ultrasound, pelvic (nonobstetric), real time with image documentation; complete
Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, after first trimester (> or = 14 weeks 0 days), transabdominal approach; single or first gestation
Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (< 14 weeks 0 days), transabdominal approach; single or first gestation
Ultrasound, pregnant uterus, real time with image documentation, follow-up (eg, re-evaluation of fetal size by measuring standard growth parameters and amniotic fluid volume, re-evaluation of organ system(s) suspected or confirmed to be abnormal on a prev . . . .
Ultrasound, pregnant uterus, real time with image documentation, transvaginal
Ultrasound, retroperitoneal (eg, renal, aorta, nodes), real time with image documentation; limited
Ultrasound, scrotum and contents
Ultrasound, transvaginal
Unclassified drugs
Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with biopsy, single or multiple
Urea nitrogen; quantitative
Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, with microscopy
Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, without microscopy
Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, with microscopy
Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, without microscopy
Urine pregnancy test, by visual color comparison methods
Visual field examination, unilateral or bilateral, with interpretation and report; extended examination (eg, Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30 degrees, or quantitative, automated thresho . . . .
Vitamin D; 25 hydroxy, includes fraction(s), if performed
Wet mounts, including preparations of vaginal, cervical or skin specimens