

MEMORANDUM

To: Health Connector Board of Directors
Cc: Jean Yang, Executive Director
From: Ed DeAngelo, General Counsel
Kaitlyn Kenney, Director of Policy & Research and Coordinator of National Health Care Reform
Date: March 11, 2013
Re: Minimum Creditable Coverage Regulations – Public Comment Summary and Adoption of Final Regulations

Health Connector staff recommends a final vote on the Health Connector’s proposed amendments to the Minimum Creditable Coverage (MCC) regulations (956 CMR 5.00), inclusive of some adjustments to the draft regulations the Board voted on at the December 13, 2012 Board meeting. The purpose of this memorandum is to summarize public comments and testimony related to the Health Connector’s proposed amendments to the MCC regulations and then to discuss these comments and briefly explain the rationale for any proposed changes in light of these comments or other considerations.

BACKGROUND

The MCC regulations specify the minimum value or level of benefits that an adult must have in order to satisfy the Commonwealth’s individual mandate requirement. These regulations have been in effect since 2007 and have been updated periodically since that time. Most recently, on December 13, 2012, this Board voted to issue draft amendments to the Health Connector’s MCC regulations. The purpose of these amendments is largely to align certain components of the state’s coverage standards with key insurance market reforms instituted by the Affordable Care Act (ACA) and its associated regulations. In addition, the amendments also included some “clean up” of the existing regulations intended to strike and remove certain components that are no longer applicable.

Specifically, the proposed amendments addressed the following:

- Maximum Out of Pockets (MOOPs): The current regulations specify MOOP limits of no more than \$5,000 (individual)/\$10,000 (family), if a health plan includes a deductible or co-insurance on in-network covered core services. The current regulations also require that a health plan’s MOOP calculation must include co-payments over \$100, co-insurance and deductibles; however, cost-sharing for prescription drugs need not count toward the MOOP.

The proposed amendments modify the base amounts in effect for MOOPs (from the \$5,000 (individual)/\$10,000 (family)), to align with the Internal Revenue Code limits allowed for High Deductible Health Plans (HDHPs) in 2014. Subsequent to 2014, these MOOPs are indexed to average annual national premium growth. In addition to amending the base MOOPs and instituting an indexing approach, the proposed amendments also introduce a revised methodology for calculating the MOOPs. The proposed approach would require all cost-sharing for Essential Health Benefits (EHBs) to accumulate towards the MOOP; this is inclusive of cost-sharing for prescription drugs since prescription drugs are considered an EHB.

- Deductibles: The current regulations specify medical deductible limits of no more than \$2,000 (individual)/\$4,000 (family) for in-network covered services. In addition, if a health plan has a separate prescription drug deductible, this deductible may be no more than \$250 (individual)/

\$500 (family), however, this deductible may be in addition to the medical deductible, resulting in a plan having a combined deductible of, for example, \$2,250 (individual)/\$4,500 (family).

The proposed amendments index, in years after 2014, the base deductible amounts for both medical and prescription drugs to average annual national premium growth. In addition, the amendments modify the deductible limits such that they represent a combined limit on any medical and prescription drug deductibles (*i.e.*, if a plan has a separate prescription drug deductible, that must be considered as part of the overall deductible limit of \$2,000 (individual)/\$4,000 (family)).

- Catastrophic Health Plan: The ACA introduces a health plan referred to as a catastrophic health plan that is available only to those who are under 30 or exempt from the federal mandate on affordability or hardship grounds. These plans are required to provide coverage for EHBs and the plan design is structured, by statute, such that no coverage is provided (with the exception of preventive care and three primary care visits) until the MOOP has been satisfied. The proposed amendment adds Catastrophic Health Plan to the list of health plans that are deemed MCC-compliant.
- Other Clean Up: Since the MCC regulations have been phased in over time, there are certain sections of the regulations pertaining to prior time periods that are no longer applicable. For example, there is a section of the regulations addressing the types of health insurance that are considered MCC-compliant for the period ending December 31, 2008. The proposed amendments strike language such as this which is now moot.

SUMMARY OF PUBLIC HEARING AND WRITTEN COMMENTS

The Health Connector issued the amended MCC regulations for public comment following the Board meeting on December 13, 2012 and held a public hearing at Gardner Auditorium on Tuesday, January 22, 2013 at 10 a.m. The Health Connector received written comments from the Affordable Care Today (ACT!!) Coalition, Blue Cross Blue Shield of Massachusetts (BCBSMA) and Health Law Advocates (HLA). Testimony was provided at the hearing by Buck Consultants, Massachusetts Association of Health Plans (MAHP) and the Massachusetts Chiropractic Society, Inc (MCS). The full text of comments and testimony (if submitted in writing) is available upon request. Summarized below are those comments received which suggest an alternative approach or additional amendments to what has been proposed.

The ACT!! Coalition's comments indicated opposition to the indexing of the deductible limits. The Coalition expressed concern that adopting the federal approach of adjusting these limits in line with national average premium growth will result in increased exposure to health care costs for consumers. Similarly, the ACT!! Coalition opposes the proposal to adjust the MOOP limits to align with those allowed for HDHPs as instituted by the ACA for small and non-group products.

BCBSMA included several comments specific to pediatric dental benefits for purposes of satisfying the ACA's EHB requirements. In particular, BCBSMA recommended that the regulations also include the allowance for a separate pediatric dental deductible, either for plans that include this as an embedded benefit or on a stand-alone basis. In addition to the allowance for a separate pediatric dental deductible, they also suggest the importance of the allowance of a separate pediatric dental MOOP. In both of these areas, BCBSMA has indicated they are awaiting guidance from the U.S. Department of

Health and Human Services (HHS) to confirm this approach is permissible. Their comments suggest these features are necessary due to the different claims adjudication systems relied upon for processing medical and dental claims.

BCBSMA offered comments with respect to the proposed MOOP changes. BCBSMA recommends that all grandfathered plans (as defined by HHS for purposes of implementing insurance market reform rules introduced by the ACA) be exempt from MOOP requirements. With respect to the proposed change that all cost-sharing for EHBs count toward the MOOP, BCBSMA expressed concern that this will add cost to self-insured and fully insured plans. In addition, they expressed concern that this may result in provider and member confusion, as providers collecting co-pays at the point of service may not realize that an enrollee has met his/her MOOP. BCBSMA also highlighted that the proposed regulations do not specifically allow for a separate pharmacy MOOP; their comments indicate that a combined MOOP for medical and pharmacy costs requires vendor integration that is administratively burdensome and costly. They suggest the explicit allowance of a separate pharmacy MOOP that, when combined with the medical MOOP, does not exceed the maximums specified in the regulations.

BCBSMA also raised concerns with respect to the proposed effective dates of several of the amendments proposed (most were initially drafted such that they become effective as of January 1, 2014). BCBSMA indicated that many of the ACA insurance market reform provisions are required to be implemented upon the start of a plan year on or after January 1, 2014, and therefore they urged the regulations be modified to align with this timeline.

The comments provided by HLA indicated endorsement and support of the comments provided by the ACT!! Coalition. In addition, they recommend that the regulations be amended to specifically include “prenatal and delivery services” within the “maternity and newborn care” service category included in the current list of the broad range of services that must be covered (965 CMR 5.03(1)(a)). HLA suggests that the omission of prenatal and delivery services may have been an unintended oversight resulting from the deletion of the definition of “preventive care,” which included well baby care and prenatal care.

Buck Consultants provided both oral and written testimony at the public hearing. Their comments focused on the amendment to the regulations requiring all co-payments for EHBs to count toward the MOOP. In particular, the comments suggested that there is still uncertainty as to if federal regulations will require this for large employer plans and that in the absence of that federal requirement, this will be problematic for large employers. Like BCBSMA, Buck Consultants also referenced the fact that grandfathered health plans are not subject to this requirement under the federal law. Their recommendation is that the MCC regulations employ the same requirement for large group plans as is implemented federally.

According to Buck Consultants, if the MOOP limits do not apply under federal law (to large employers), but are included in the state MCC regulations, employers will pursue one of three options, including: (1) modification of the plan design to comply with the requirement, which they characterize as unlikely because of the associated effort and costs, (2) maintenance of their current plan design, which may result in employees being subject to the state penalty for failure to comply with the mandate, or (3) submission of the plan to the Health Connector for MCC certification (on the basis of the actuarial value of the plan). Finally, Buck Consultants suggested that the Board delay implementation of the changes to the MCC regulations until at least 2015 in an effort to provide large employers with additional time necessary to plan and implement changes and focus current efforts on compliance with the ACA.

MAHP also provided both oral and written testimony at the public hearing. Their comments focused on MOOPs and on Massachusetts residents obtaining small group coverage in other states. With respect to MOOPs, they recommended the regulations be further amended to allow for a separate MOOP for pharmacy costs so long as the combined costs for medical and pharmacy do not exceed the MOOP. According to their comments, this approach is necessary in instances where pharmacy coverage is provided through a carve-out arrangement. The additional recommendation provided by MAHP was to include language intended to deem a small group health benefit plan that complies with the EHB benchmark in another state as compliant with the Commonwealth's MCC standards.

The testimony provided by the MCS, Inc. focused on the need for the MCC regulations to include language regarding the principle of non-discrimination. According to MCS, a health plan that includes coverage for manual services but excludes chiropractic providers represents a discriminatory benefit design. MCS has requested the following language be added to 956 CMR 5.03(1)(b), "Exclusions and limitations on benefits will be identified in plain language and non-discriminatory in their design and application." MCS also requested the Health Connector modify a prior administrative bulletin that offers chiropractic as a service that may be excluded from a plan that would meet MCC requirements; instead, MCS suggests the bulletin be revised to describe an excluded procedure, rather than a class of providers.

DISCUSSION AND ANALYSIS OF COMMENTS

After careful consideration of the comments received by the Health Connector, we propose to proceed with some adjustments and additions to the draft regulations as described below. It is important to note that the final EHB, Actuarial Value and Accreditation rule was released after the public hearing and following the closure of the public comment period. Consequently, many of the issues surfaced in the testimony and comments provided have been addressed in this federal regulation.

A significant portion of the comments we received pertained to proposed amendments addressing MOOP requirements. Summarized below is our response to the issues highlighted on this topic.

While we appreciate the ACT!! Coalition's comments opposing the indexing of deductibles and MOOPs, we respectfully propose maintenance of the approach proposed in the draft regulation. We believe that this approach will provide modest additional flexibility with product design and be responsive to longstanding concerns of employers and health plans. In response to the ACT!! Coalition's comment that these changes will result in increased exposure to health care costs for consumers, it is important to note that coupled with these changes is also a change with respect to how MOOPs are calculated. While our proposed changes to the base amount for MOOPs and the indexing of MOOPs may theoretically increase allowed cost-sharing, the regulations also expand the cost-sharing that must count toward this MOOP. The requirement that all cost-sharing for EHBs must count toward the MOOP represents a significant and meaningful change from the current approach which allows the exclusion of co-payments less than \$100 and all cost-sharing for pharmacy.

BCBSMA and Buck Consultants also offered comments with respect to some of the proposed changes relative to MOOPs. Both indicated concern associated with the requirement that all cost-sharing for EHBs apply to the MOOP, highlighting that this approach may not necessarily be required of large group, self-insured and grandfathered plans under the federal regulations. The final rule does indeed specify

that the MOOP requirements are applicable for all non-grandfathered group plans (*i.e.*, this includes fully insured large group and self-insured plans). It is our understanding that there will be few plans that remain in “grandfathered status” serving the Massachusetts population. Consequently, those plan sponsors that offer a grandfathered plan which is not compliant with this provision, but that otherwise provides sufficiently robust coverage, may rely on the Health Connector’s MCC Certification process. In addition to the importance of the federal guidance in informing our perspective on this provision, we also believe one of the fundamental reasons for maintaining the state’s MCC regulations is to mitigate inequities between large and small employers (which may result from differential application of certain ACA insurance market reform provisions). While we recognize this may present some new operational considerations for health plans and large employers, our understanding is that this is something that they will be required to develop even in the absence of the state’s MCC regulations. Consequently, we recommend maintenance of the approach initially proposed in the regulations.

Related to the above is the concern BCBSMA and MAHP highlighted regarding the complexity of integrating cost-sharing across separate vendors in instances where certain components of a health plan are carved out. We appreciate the concern presented here and believe that the recommendation proposed – to allow for separate MOOPs in these instances so long as they do not exceed the maximums specified in the regulations when summed – is a consumer-friendly approach. We have made a modest revision to the regulations to allow this approach.

BCBSMA also raised the concern that the initial draft MCC regulations required many of the proposed changes, specifically those pertaining to MOOPs and deductibles, to be effective as of January 1, 2014, while the federal requirements are for these changes to become effective for plan or policy years beginning on or after January 1, 2014. In an effort to maintain consistency with the federal approach, we propose to modify the effective date of the new provisions pertaining to MOOPs and deductibles to plan or policy years beginning in 2014 as opposed to as of January 1, 2014.

The sections below respond to those comments focusing on non-MOOP related issues.

As BCBSMA indicated in their comments, the EHBs include a pediatric dental component which may be offered as an embedded or standalone benefit. We appreciate BCBSMA’s comment regarding the allowance for a separate pediatric dental deductible given the challenge of integrating claims processing systems across medical and other (*e.g.*, pharmacy or dental) claims. Moreover, it does not appear that the federal regulations would preclude a separate pediatric dental deductible. Consequently, we propose to add additional language to the regulations that would allow an embedded pediatric dental benefit (or other benefits like prescription drugs) to have a separate deductible, so long as the combined deductibles do not exceed the overall deductible limitations (*i.e.*, \$2,000 (individual)/\$4,000 (family) in 2014). Like the addition described above allowing separate MOOPs, this ensures that deductible limits are maintained, while providing a mechanism for plans that rely on these plan features but do not integrate claims processing to meet these requirements.

In response to HLA’s comments, we concur with their analysis and agree that the initial proposed amended regulations could unintentionally omit the requirement for inclusion of the prenatal delivery services, which exists in our current regulations and is not intended to be removed. Therefore, to avoid this, we recommend modification to section 5.03(1)(a)(5) of the draft proposed regulations to include, “Maternity and newborn care, including prenatal care, post natal care, and delivery and inpatient services for maternity care.”

With respect to the concerns Buck Consultants raised in regards to employer behavior in response to our proposed approach, it is our strong hope that our approach – which generally builds upon the final federal rules and aligns with requirements nationally – will enable employers to continue to demonstrate support for the Commonwealth’s strong coverage standards. In instances where an employer or plan sponsor is unable to meet the technical letter of the law, we will continue to offer the MCC Certification process.

In addition to their comments relative to MOOPs, MAHP commented that a provision should be added to the regulations such that a plan meeting the EHB requirements in another state is deemed compliant with the state MCC regulations. The rationale provided was that no resident should be penalized if their plan is ACA-compliant. This would undermine one of the intentions of maintaining our MCC regulations, which is to continue to promote high value coverage regardless of the market through which that coverage is acquired. Put another way, adoption of this concept would be inconsistent with current regulations and our proposed changes; our regulations may in fact require an individual to have a plan with features that are not technically required of that plan under the ACA. For example, according to MCC regulations, an individual must have a plan that includes coverage of prescription drugs to meet the state mandate requirement. Under the ACA, an individual can satisfy the mandate requirement with a plan that may not include prescription drugs.

It is important to clarify that while states may have some differences in terms of what is included in their respective EHB package, there is a statutory basis for the ten categories of services that must be included in the EHB across all states. These categories of services align closely with the categories of services included in the MCC regulations with respect to the broad range of medical services that must be included in a plan. Therefore, it is unlikely another state’s EHB selection would not meet the MCC criteria with respect to the scope of services that it covers. Moreover, this plan will also likely meet the cost-sharing components of the MCC regulations since as a small group it would be subject to the ACA insurance market reforms pertaining to deductibles and MOOPs. The one caveat to this latter point would be in instances where a small employer in another state opts to provide a plan with a deductible greater than the \$2,000 (individual)/\$4,000 (family) limit allowed based on an actuarial justification that this enhanced deductible is necessary to meet a particular actuarial value and metallic tier. In these types of instances, just as is the case today, we would recommend that the employer or plan sponsor rely upon the MCC Certification process to review this technical deviation from the state’s MCC requirements.

Finally, we propose to add language, as suggested by MCS, to 956 CMR 5.03(1)(b) indicating that “Exclusions and limitations on benefits should be identified in plain language and non-discriminatory in their design and application.”

CONCLUDING REMARKS

In summary, we issued draft regulations for public comment related to proposed amendments to the Commonwealth’s MCC regulations (956 CMR 5.00). Upon review of the comments that we received, we have recommended some additional changes to the draft regulations that were voted on at the December 13, 2012 Board meeting. At the Board meeting on Thursday, March 14, 2013, we will present our recommendation with regard to the final MCC regulations for which we seek Board approval.