Health Connector logo2024 Reporting Form for Health Arrangements Provided by an Established Religious Organization

(For Organizations Seeking Minimum Creditable Coverage Status in Calendar Year 2024)

The purpose of this form is for health arrangements provided by an established religious organization to provide the Massachusetts Health Connector with certain information related to membership, operations, and finances.

A complete and timely response to this form satisfies one of the criteria for a health arrangement provided by an established religious organization to be deemed to provide minimum creditable coverage (“MCC”).[[1]](#footnote-1) The Health Connector may—after review of this form and any attendant submissions—require additional information or clarifications regarding a health arrangement’s membership, operations, and finances.

This version of the form is specific to calendar year 2024 (the “MCC Reporting Year”). Established religious entities seeking to meet the MCC reporting requirement for this MCC Reporting Year should complete this form no later than March 31, 2024.

Unless otherwise noted, responses should include aggregate data about the calendar year *prior* to the MCC Reporting Year (2023) as well as any known changes for the MCC Reporting Year (2024). Questions about this form may be directed to [MCC.Certification@mass.gov](mailto:MCC.Certification@mass.gov).

# Please provide the following information for the previous calendar year (January 2023–December 2023) unless otherwise noted:

## Organization Information

|  |  |  |
| --- | --- | --- |
|  | Jan. 2023-Dec. 2023 | Please indicate if the response for calendar year 2023 is the same for 2024. If not, please indicate any notable changes for calendar year 2024. |
| Legal name of established religious organization (if applicable, list any other “doing business as” names) |  |  |
| Legal name of health arrangement (if applicable, list any other “doing business as” names) |  |  |
| Executive leader of organization |  |  |
| Contact information for executive leader |  |  |
| Organization mailing address |  |  |
| Organization’s primary site of operation |  |  |
| Organization phone # |  |  |
| Organization website |  |  |
| Contact name for this form |  |  |
| Contact phone # |  |  |
| Contact email address |  |  |

## Operational Information

|  |  |  |
| --- | --- | --- |
|  | Jan 2023-Dec 2023 | Please indicate if the response for calendar year 2023 is the same for 2024. If not, please indicate any notable changes for calendar year 2024. |
| Were there circumstances in which members/participants were subject to fees, additional sharing requirements, or termination? (Y or N)  If yes, please list and describe them. |  |  |
| Did any third-party vendors or administrative partners act on behalf of your health arrangement to assist with the marketing, sales, and administration of the health arrangement? (Y or N)  If yes, please list and describe them. |  |  |
| Please list other states in which the health arrangements operated or advertised. |  |  |
| Did your organization directly contract with health care providers for services received by member/participants? (Y or N)  If yes, please describe the nature of these contracts. |  |  |

## Membership/Participation Information for the previous calendar year (2023)

|  |  |  |
| --- | --- | --- |
|  | Massachusetts | National (If you cannot provide this data, please explain why) |
| Total number of members/participants (please provide individual member level data) |  |  |
| Did any small businesses offer your health arrangement to their employees or facilitate the arrangement for their employees? (Y or N)  If yes, please list the number of small businesses and employees. |  |  |
| If any small businesses offer your health arrangement to their employees or facilitate the arrangement for their employees, did any employers contribute toward the cost of the arrangement? |  |  |
| If you had different sharing arrangement types, please provide membership breakdown by sharing arrangement type. |  |  |

## Financial Information for the previous calendar year (2023)

|  |  |  |
| --- | --- | --- |
|  | Massachusetts | National (If you cannot provide this data, please explain why) |
| What were the total share amounts contributed by members/participants? |  |  |
| What was the total amount submitted to the health arrangement by members/participants for sharing? (This should include all submissions by members/participants, not just qualifying submissions). |  |  |
| What was the total qualifying sharable amount submitted by members/participants? |  |  |
| Does the health arrangement negotiate rates? (Y or N)  If yes, who does the negotiating (your members, your organization, or other entities)? |  |  |
| What was the total amount paid through the health arrangement for members’/participants’ submitted health care costs? |  |  |
| What were the health arrangement’s administrative fees per member?  (If the administrative fee amount per member/participant changed, e.g., based on type of membership or length of membership, please detail all fees and the circumstances under which they occurred). |  |  |
| Does the health arrangement use actuaries, including to set shares or determine sharing policy? (Y or N)  If yes, please describe how actuaries are used. |  |  |
| Do members have the opportunity to appeal amounts paid or not paid through the health arrangement for members’/participants’ submitted health care costs? (Y or N)  If yes, please describe the appeal process. |  |  |

# Please attach the following documents used during the previous calendar year (2023) and if different, MCC Reporting Year (2024)

* Written disclosures that the organization make available in conformance with 956 CMR 5.03(3)(d)5
* All marketing materials or brochures
* Guidelines or other member-participant or public-facing materials that explain sharing terms & conditions
* The organization’s audited financial statements (if your organization has no audited financial statements, please provide any available unaudited financial statements)

A health arrangement provided by an established religious organization is deemed to provide minimum creditable coverage under 956 CMR 5.00 provided that the organization meets the following standards. Please attest to the standards your health arrangement meets during the MCC Reporting Year (2024):

|  |  |
| --- | --- |
|  | *is not a for-profit organization;* |
|  | *does not make any direct or indirect representation that the organization has sufficient financing to meet members’ anticipated financial or medical needs or that it has had a successful history of meeting members’ financial or medical needs, provided that this requirement shall not apply to any financial statement that the organization is otherwise required to disclose by law;* |
|  | *does not use compensated sales agents, sales tactics, or deceptive marketing practices to solicit or enroll members, including that it does not use common insurance terms, such as “health plan,” “coverage,” “copay,” “copayment,” “deductible,” “premium,” and “open enrollment,” or refer to itself as “licensed” in advertisements, marketing material, brochures, or other materials related to the arrangement;* |
|  | *does not use funds paid by members for medical needs to cover administrative costs;* |
|  | *provides disclosure that the organization is not an insurance company and does not guarantee that medical bills will be paid by the organization or any other individuals; such disclosure must be made at initial contact with a prospective member, at the time of any material modification to the terms of the sharing arrangement, and in all advertising, brochures, and marketing materials; and* |
|  | *reports annually to the Health Connector any information about membership, operations, and finances as the Health Connector may require.* |

Signature of senior corporate officer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Title of senior corporate officer: ­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
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| If applicable, please offer any explanations regarding the above attestation |  |

Please email your completed form to [MCC.Certification@mass.gov](mailto:MCC.Certification@mass.gov).

*As a public entity, the Health Connector is subject to the Massachusetts Public Records Law (M.G.L. c. 66 and 66A) and thus certain documents and other materials made or received by the Health Connector are subject to public disclosure unless they are specifically exempted. By completing this form, respondent specifically acknowledges that it bears the risk that any material it submits to the Health Connector pursuant to this form may be deemed not to qualify for a public records exemption. Further, the Health Connector may, in its discretion, choose to make some or all of the material submitted public, including in reports or otherwise.*

1. 956 CMR 5.03(3)(d)6. [↑](#footnote-ref-1)