Minimum Creditable Coverage, Minimum Essential Coverage and ACA Insurance Market Reforms

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Introduction

- The purpose of today's presentation is to review state and federal health insurance coverage standards
- There are two ways in which coverage standards are imposed:
  - Regulation of coverage that can be sold in the market
  - An individual mandate requiring people to have a minimum level of coverage to avoid penalties
- State and federal reform rely on both mechanisms to impose coverage standards

Key Concepts

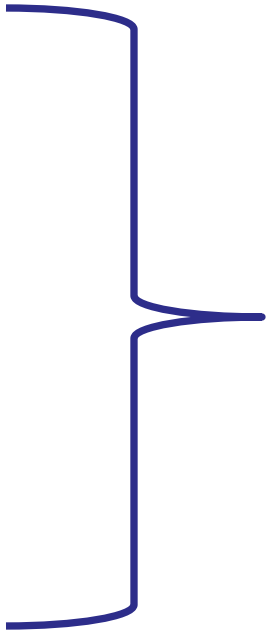
- **Massachusetts Coverage Standards:**
  - Many (~30) state mandated benefits that are required to be covered in all fully insured plans (*e.g.*, maternity care, mental health care, infertility, et al.)
  - MCC is the standard to satisfy the state individual mandate
    - MCC has a number of different components, including designating specific types of coverage, per statute, as per se compliant
    - For other forms of coverage, the Health Connector adopts regulations specifying services that are required to be covered, imposing some limits on out-of-pocket (OOP) costs and prohibiting certain forms of limitations on benefits
    - The Health Connector also administers an MCC Certification process which allows health plans that have modest deviations from the MCC regulations, but have an actuarial value equal to or better than a Bronze plan, to be deemed MCC-compliant
- **ACA Coverage standards**:
  - Several new insurance market reforms related to covered benefits and cost-sharing largely focused on the small/non-group fully insured market
  - MEC is the standard to satisfy the federal individual mandate requirement
    - MEC includes broad categories of coverage that satisfy the individual mandate

Key Concepts (cont'd)

MCC	MEC
• Specific categories of coverage that are "per se" compliant with MCC: – Government plans (Medicare, Commonwealth Care, Tricare, VA, Peace Corps, AmeriCorps) – Federal employee coverage – YAPs – Student health insurance – Indian health service plans – Coverage provided by religious organizations • Plans that meet the benefit and cost-sharing standards detailed in the MCC regulations • Plans that acquire MCC Certification through the Health Connector	• Broad categories of coverage that are "per se" compliant with MEC: – Government plans (Medicare, Medicaid, CHIP, Tricare, VA, Peace Corps, others TBD by Secretary) – Employer plan* – Individual plan* – Grandfathered plan* *There are several private insurance market reforms instituted through the ACA that may apply to these different categories of coverage. Most of the benefit standards and cost-sharing requirements apply only to individual and small group employer plans.

ACA Insurance Market Reforms

- The ACA introduces insurance market reforms relative to:
  - EHB coverage requirements
  - Cost-sharing limitations
    - Deductibles
    - Out-of-Pocket Maximums
  - Coverage limitations
    - Annual Limits
    - Lifetime Limits
  - Preventive care requirements



These reforms, and their relationship to MCC, will be discussed in more detail in subsequent Board meetings on this topic.

ACA Insurance Market Reforms: EHBs

- The ACA requires all small and non-group fully insured plans inside and outside the Exchange to provide coverage for EHBs. Per statute, the EHBs must include coverage for the following categories of care:
  - Ambulatory patient services
  - Emergency services
  - Hospitalization
  - Maternity and newborn care
  - Mental health and substance use disorder services, including behavioral health treatment
  - Prescription drugs
  - Rehabilitative and habilitative services and devices
  - Laboratory services
  - Preventive and wellness services and chronic disease management
  - Pediatric services, including oral and vision care

ACA Insurance Market Reforms: EHBs (cont'd)

- To further define what constitutes EHBs, a bulletin issued by the U.S. Department of Health and Human Services (HHS) directed each state to select a benchmark plan that reflects the scope of services offered by a typical employer plan in the state
- The bulletin indicated the benchmark plan should be selected from one of the following options:
  - One of the three largest (by enrollment) small group plans in the state
  - One of the three largest (by enrollment) state employee health plans
  - One of the three largest (by enrollment) federal employee health plan options
  - The largest (by enrollment) HMO plan offered in the state's commercial market
- The benchmark plan selected must cover all of the categories of services identified in statute
  - If the benchmark plan selected does not cover all ten categories, the state will have the option to examine other benchmark options to determine the type of benefits that must be included for that category

ACA Insurance Market Reforms: EHBs (cont'd)

- The benchmark selected by the state is significant as it sets the benefit coverage standards for all fully insured health plans in the small/non-group market
  - To meet the EHB coverage standard, health plans must offer benefits that are "substantially equal" to the benchmark plan selected by the state
  - Health plans have some flexibility to modify coverage within a benefit category, but they must continue to offer coverage for all ten statutory categories and the coverage must have the same value as the benchmark
- In Massachusetts, the Division of Insurance (DOI) was granted the authority to make this selection and conducted an analysis of the ten options under consideration
- The benchmark plan selected for the state is BCBSMA HMO Blue (and HPHC Best Buy HMO for pediatric dental services), which is the largest small group plan in the state

High-Level Coverage Standards Comparison

	STATE		FEDERAL	
	MCC • Required benefits (including prescription drugs) • Limits on cost-sharing	**Benefit Mandates** • Required benefits (*e.g.*, preventive care up to age six, mental health, PKU, infertility, et al.) • Does NOT include prescription drugs	**MEC** • No required benefits • No limits on cost-sharing	**ACA Market Reforms** • Required benefits (*i.e.*, EHBs) • Limits on cost-sharing
Small/Non-Group	√	√	√	√*
Other Fully Insured	√	√	√	N/A
Self-Funded	√	N/A	√	N/A

*Some ACA market reforms extend to other fully insured and self-funded plans (*e.g.*, prohibition on lifetime limits).

High-Level Coverage Standards Comparison (cont'd)

- There are some important implications resulting from the fact that large group and self-insured plans are not required to cover EHBs. For example:
  - Under the federal coverage standards, a large employer plan, by definition, meets MEC. However, the large employer plan is not required under the ACA to provide EHBs
  - Therefore, an individual may have an employer plan that fails to provide one, or several, of the categories of coverage required in EHBs (*e.g.*, prescription drugs). This would meet MEC requirements, but fail to meet MCC requirements

Key Takeaways

- The fundamental difference between the state and federal approaches is:
  - The state coverage standards (MCC) include ***a few*** categories of "per se" compliant coverage, but then include coverage and cost-sharing requirements ***regardless of where an individual receives coverage***
  - The federal coverage standards (MEC) include ***almost all*** categories of coverage as "per se" compliant, and though there are separate coverage and cost-sharing requirements introduced by the ACA, they are ***highly concentrated on only the small/non-group fully insured market***
- This difference raises an important policy question

Does there continue to be a role for MCC to maintain Massachusetts' commitment to protecting the quality of coverage people receive?

Key Takeaways (cont'd)

- If MCC standards should remain, some key issues to consider include:
  - What are the MCC standards?
    - There may be some adjustments to MCC to consider given ACA insurance market reforms (however, MCC standards *cannot* be designed to equate to the scope and detail of the EHB requirements)
  - How are MCC standards enforced?
    - Maintenance of MCC requires the continuation of a state individual mandate imposing tax penalties for adults who can afford but lack MCC-compliant coverage
    - Need to ensure that there are no double penalties, that state affordability standards are set at appropriate levels, and that the federal and state administrative and enforcement processes are appropriately meshed

Next Steps

Action Item	Timeline
• Solicit feedback from the Board regarding retention of MCC requirements (today)	✓
• Enhance analysis of state coverage standards vs. federal coverage standards	October-November
• Further discussions about MCC with the Individual Mandate Advisory Committee – Includes diverse stakeholders representing consumer groups, employers, carriers, think tanks, state agencies and some Health Connector Board members	November
• Revisit this issue with the Board to outline approach for moving forward	November or December