



Draft Minimum Creditable Coverage Regulations Amendments

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Overview

- 1. Refresher on Minimum Creditable Coverage (MCC)**
- 2. Overview of recommended changes**
- 3. Recommended changes in detail:**
 - MCC deductible limits
 - Health arrangements established by religious organizations
 - Technical/organizational updates
- 4. Proposed next steps**

Overview of Proposed Recommendations

Since the Health Connector's MCC regulations were last updated in 2013, as part of early Affordable Care Act (ACA) implementation, the Health Connector has identified narrow areas in the regulations that would benefit from updates and clarification.

- The Health Connector's Minimum Creditable Coverage (MCC) regulations have played a central role in Massachusetts's 13 year reform effort and its individual mandate, contributing to Massachusetts having the leading rate of insurance coverage in the nation. These regulations ensure Massachusetts residents have access to meaningful, comprehensive coverage
- Today, a small number of discrete aspects of the Health Connector's MCC regulations are out of alignment with market dynamics and current Health Connector practice
- As detailed in this deck, staff respectfully request that the Board issue for public comment draft amendments to the regulations at 956 CMR 5.00 to better align with market dynamics and current Health Connector practice:
 - Reinstate indexing of MCC deductible limits from 2013
 - Clarify current standards used to define health arrangements established by religious organizations
 - Technical and organizational updates
- If the Board votes to issue draft regulations today, staff will return to the Board in December to review comments received and finalize the regulations

Health Connector's Role in Defining Minimum Creditable Coverage (MCC)

As part of Chapter 58 reforms dating back to 2006, Massachusetts law requires adult residents to have health insurance that meets the state's Minimum Creditable Coverage (MCC) standards or potentially face an individual mandate penalty.

- The state's individual mandate law (M.G.L. c. 111M, s. 1) defines MCC at a high level and provides the Health Connector Board with the authority to further determine the minimum standards of the plans that individual residents are required to have (via MCC regulations)
- MCC has a wide reach; over 4 million Massachusetts residents are subject to MCC standards
- The Health Connector's MCC regulations are intended to offer a minimum coverage floor, to ensure basic consumer protection for Massachusetts residents while retaining affordability, which includes ensuring individuals aren't unnecessarily penalized when they have reasonable, market standard coverage
- Today, the Health Connector's MCC standards are especially important in offering a framework for acceptable coverage in Massachusetts because the federal individual mandate penalty has been zeroed out

MCC Compliance Process

The Health Connector oversees compliance with its MCC regulations, setting standards for individuals and issuing educational guidance to the broader market.

- MCC requirements apply to individuals, not health insurance plans or employers
- If adult residents fail to have MCC-compliant coverage for 3 consecutive months:
 - A tax penalty may be assessed if the resident has access to coverage that meets the Health Connector's Affordability Schedule
 - Individuals can appeal state tax penalties for hardship or other circumstances
- To assist with individual compliance, the Health Connector manages a process to determine whether coverage meets MCC standards (*see Appendix*)
 - Most plans are self-certified as MCC because the employer, carrier, or plan sponsor determines their plan satisfies MCC standards and annually provides a 1099-HC to each subscriber or covered individual in MA
 - Some plans are categorically compliant and automatically meet MCC, such as Medicare, MassHealth, Veteran's Administration coverage or any plan offered by the Health Connector
 - Other plans can submit an MCC Certification Application to the Health Connector for review if they deviate from certain MCC standards



Overview of the Changes in the Proposed Regulation

Overview of Proposed Recommendations

Staff recommend the following targeted amendments to the MCC regulations:

Insurance Coverage Topic	Overview of Proposed Regulatory Change	Reasons for Update
Deductible limits	<ul style="list-style-type: none"> Reinstate indexing of MCC deductible limits from 2013, approved by the Board but did not take effect due to drafting issues Authorize the Board to amend indexed deductible in any given year via a vote 	<ul style="list-style-type: none"> Repair the broken indexing cross-reference to ensure that MCC deductible limits can account for inflation
Health Arrangements Established by Religious Organizations	<ul style="list-style-type: none"> Clarify current standards used to define these entities and ensure they are bona fide organizations 	<ul style="list-style-type: none"> Address surge in non-ACA compliant plans offering non-comprehensive or fraudulent coverage to consumers under the guise of health arrangements established by religious organizations
Technical/organizational updates	<ul style="list-style-type: none"> Update definitions, remove dated references, clarify meaning of certain requirements, reorder provisions 	<ul style="list-style-type: none"> Improve clarity and readability of regulations



Update MCC Deductible Limits

Background on MCC's Deductible Limits

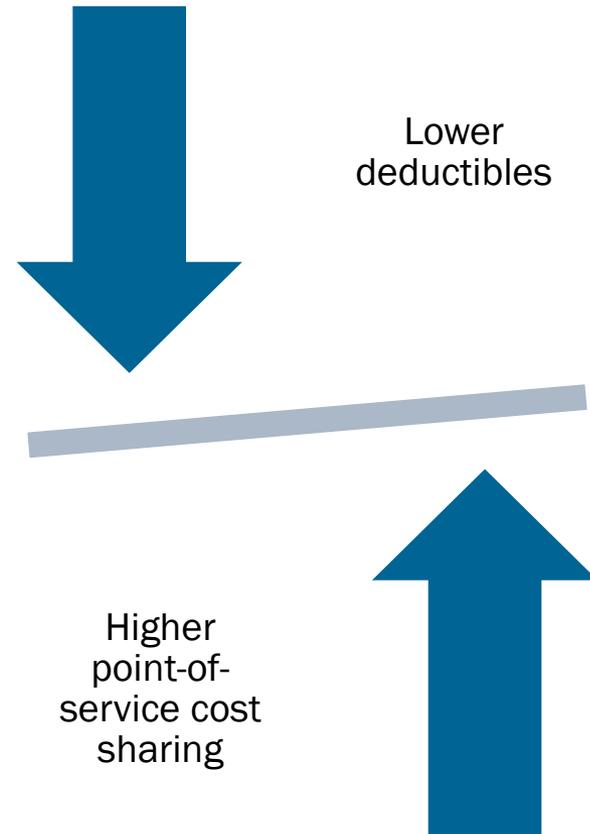
MCC regulations include deductible limits to protect residents from coverage that requires prohibitively high out-of-pocket costs before accessing care, while recognizing that deductibles can function to offset other types of individual costs, such as coinsurance.

- Current MCC deductible limits are \$2,000 for individuals and \$4,000 for families
 - Within the \$2,000/\$4,000 deductible limit, there is a separate Rx deductible limit of up to \$250/\$500
- These limits were set by the original regulations in 2007, in recognition of the importance of ensuring that individuals have meaningful coverage they can use without incurring large up-front out-of-pocket expenses
- However, current limits are out-of-step with some segments of the market and the reality of today's health care costs and inflation:
 - Due to inflation, \$2,000 in 2007 is equivalent to just over \$2,500 in 2019, according to the Bureau for Labor Statistics
 - Nationally, the average non-group bronze plan deductible is \$5,861/\$12,186 (2019)
 - Nationally, the average employee deductible in 2018 was nearly twice what it was a decade ago (\$1,573 vs. \$735) and increased 53% over the last 5 years
- In 2013, the Board recognized this market shift by approving the indexing of deductibles according to a federal indexing statute
- However, that statute was repealed before the indexing could ever take effect, which means that the deductible limits have not changed since 2007

Background (cont'd.)

Since the Board last reviewed MCC's deductible limits, the tension between deductibles and underlying health care costs has continued to grow.

- MCC applies to individuals who get coverage from across the entire market, but as an example, some of the Health Connector's own standard plans no longer meet the MCC deductible standard because of the trade-off between deductibles and point-of-service costs needed to meet federal actuarial value standards
- The Health Connector has also seen an increase in the number of plans that do not meet the MCC deductible limit requesting and receiving an MCC designation through its "Certification Application Process"
 - In 2018, the average deductibles of plans that were approved via the MCC certification application were \$3,516/\$7,686
- MCC deductible limits serve an important consumer protection function, but must be calibrated to market realities to ensure that individuals are not unfairly penalized for having coverage that meets reasonable minimum standards



Proposed Update: Reinstate 2013 Deductible Limit Indexing

The proposed amendments reprise the Board's previous decision to index deductibles with the HHS premium adjustment percentage, but add a new provision allowing the Board to make an annual adjustment as needed.

1. The proposed regulations index MCC deductible limits by the HHS premium adjustment percentage

- The premium adjustment percentage is the same standard the Board approved when the MCC regulations were revised in 2013 to index deductibles
- HHS determines this percentage annually and it has typically been published in the Notice of Benefit and Payment Parameters (NBPP), offering a clear resource to market participants seeking to understand the standard
- The percentage is used in updating other Affordable Care Act standards, such as the maximum annual limit on cost-sharing, the target enrollee contribution in the APTC calculation methodology, and the required contribution percentage for exemption eligibility

2. The proposed regulations include a provision allowing the Board to make its own annual adjustment to indexing if necessary

- Providing the flexibility for the Board to choose an alternative standard ensures that the Health Connector can respond appropriately to future conditions if necessary

Impacts of Proposed Update

- The HHS indexing methodology results in a moderate but reasonable increase from the original deductibles, considering the time period, offering appropriate market flexibility while retaining baseline consumer protection
 - Had this standard been in effect, 2019 deductibles would have been \$2,500/\$5,000
- This methodology would minimize changes to regulatory language and substance, as the current regulations already contemplate using this methodology to update deductibles
- Since MCC's maximum out-of-pocket limits are indexed by the HHS premium adjustment percentage, stakeholders will be familiar with the methodology when applying it to deductibles
- Because this methodology results in lower deductible limits than other approaches considered by staff, it is likely to have the impact of preserving lower deductibles that are still prevalent in the employer market today
- The HHS premium adjustment percentage methodology is subject to changes by federal agencies, but the proposed Board adjustment provision allows it to be tailored to Massachusetts's market needs as appropriate and preserves Board and state discretion



Health Arrangements Established by Religious Organizations

Background on MCC and Health Arrangements

Under MCC regulations dating back to 2007, any “health arrangement provided by established religious organizations comprised of individuals with sincerely held beliefs” is deemed to meet MCC, but the landscape and behavior of such organizations has changed in recent years.

- The current rule does not clearly define the standards that such “health arrangements” must meet
- Typically, arrangements satisfying this standard have been “health care sharing ministries” (HCSMs). However, a lack of detail in the regulations has meant that it is unclear whether particular arrangements are legitimate, a problem that has become apparent due to the nationwide increase in the number of HCSMs, including some entities that are falsely holding themselves out as HCSMs.
 - Estimates indicate HCSM participation has grown since passage of the ACA: from < 200,000 before 2010 to about 1 million today (self-reported enrollment data)
 - This increased prevalence has led other states to be more vigilant in their review of these organizations – see, e.g., recent WA, TX, and NH DOI enforcement activity
- Massachusetts has had a recent experience with such an entity:
 - In June 2019, Massachusetts’s DOI advised consumers that Alieria, an organization marketing itself as a health care sharing ministry, was potentially operating illegally in the state
 - In August 2019, the Health Connector opened a Special Enrollment Period (SEP) available for Massachusetts residents who are or were at any point in 2019 members of an Alieria arrangement

Proposed Update: Clarify Health Arrangement Criteria

Maintain language in the MCC regulations that permits certain health arrangements to meet MCC, while specifying the criteria that are used to identify a bona fide health arrangement provided by established religious organizations. This preserves the intent of the language while accounting for current market conditions.

1. The proposed regulations clarify that these organizations are only offering “health arrangements” that meet MCC if they:

- Are not-for-profit;
- Do not make any direct or indirect representation that the organization is operating in a financially sound manner or that it has had a successful history of meeting members' financial or medical needs;
- Do not use paid agents, sales tactics, or deceptive marketing practices;
- Do not use funds paid by members for medical needs to cover administrative costs; and
- Provide written disclosure that it is not insurance and does not guarantee payment of medical bills

2. The proposed regulations also include reporting requirements as a condition of MCC status:

- This would allow the Health Connector to require these organizations to report basic information about membership and administrative practices; and
- This would help Massachusetts understand the extent to which these types of “health arrangements” are active in the Commonwealth

Impacts of Proposed Update

- Protect consumers and the market from organizations that falsely hold themselves out as being one of these arrangements by clarifying what a “health arrangement” is for the purposes of meeting MCC
 - Clarifying the types of health arrangements that can meet MCC will ensure that “bad actors” are not able to deceptively use the broad label of a “health arrangement” in order to gain access to MCC compliant status
- Gain better information about the prevalence of these “health arrangements” in MA and the extent to which they may be entering the market from out-of-state
- Retain appropriate space for legitimate arrangements to continue to operate



Technical/Organizational Updates

Overview of Technical/Organizational Changes

Update definitions

- Co-insurance
- Co-payment
- Deductible

Improve readability

- Remove language that refers to requirements prior to January 1, 2014 or mention of “after January 1, 2014”

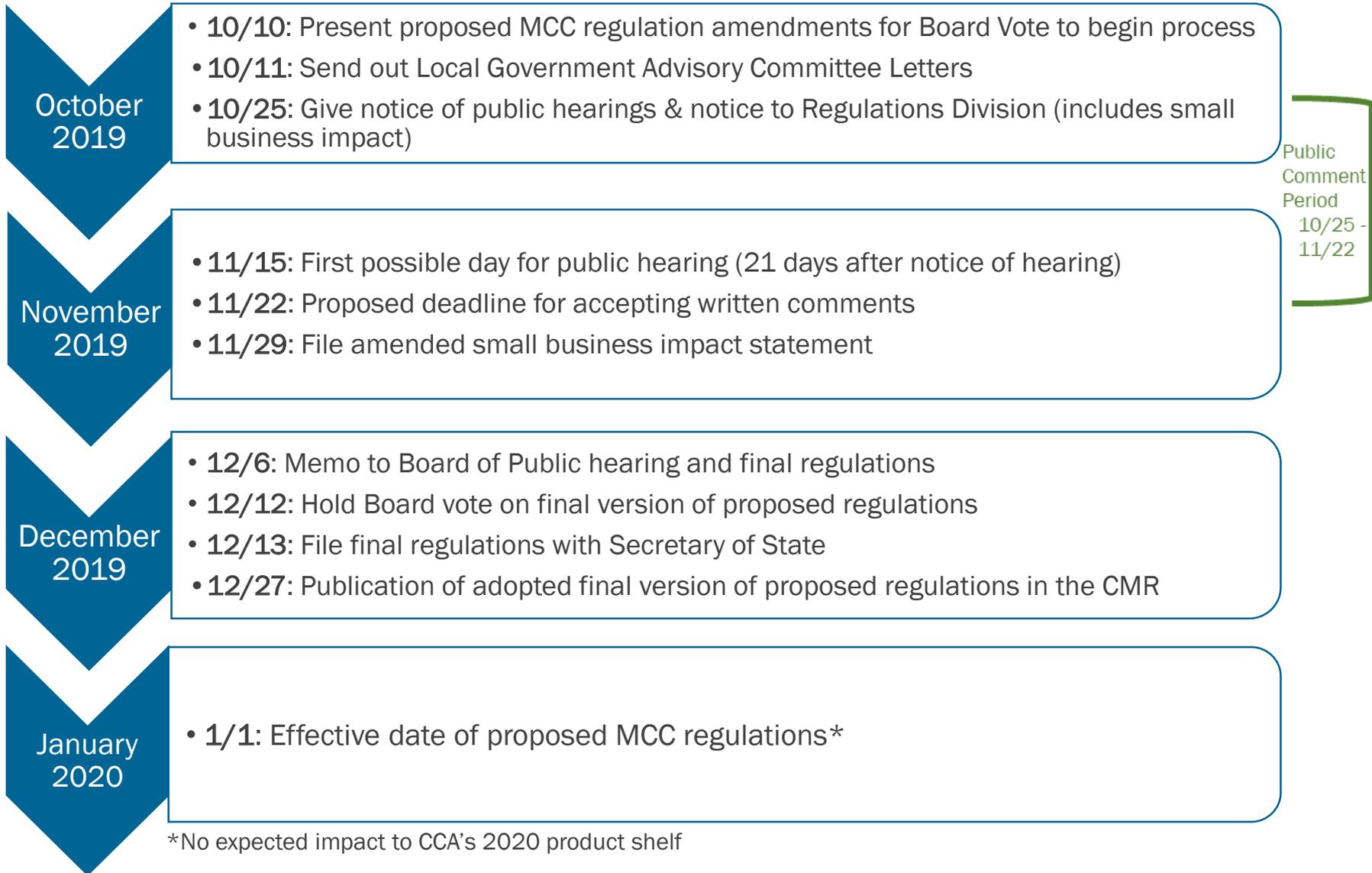
Clarify language/ Organizational restructuring

- Clarify language used to explain calculation for maximum out-of-pocket adjustments each year (based on clarifying administrative bulletin issued in 2017)
- Arrange provisions in a manner that reads clearly, and logically
- Clarify that permissible maximum benefit limitations specifically regards medical management techniques (not dollar limits), and remove examples of services that may be limited, which are not necessary



Proposed Next Steps

Proposed Regulation Amendment Timeline



Vote

Health Connector staff recommend that the Board issue the draft regulation amendments at 956 CMR 5.00, as proposed.



Appendix

Minimum Creditable Coverage (MCC) Compliance Pathways

All health plans covering a Massachusetts resident are either:

Self-Certified

Majority of plans fall into the self-certified category. Coverage is **self-certified** if employer, carrier, or plan sponsor determines their plan(s) satisfy MCC standards and annually provide a 1099-HC to each of their subscribers or covered individuals residing in MA. Plans also self-certify if they are **categorically compliant**, meaning that MCC regulations state that the type of plan is deemed minimum creditable coverage (i.e. “any health arrangement provided by established religious organizations comprised of individuals with sincerely held beliefs”).

Deemed Compliant

Coverage that does not meet all MCC standards may be **deemed compliant** by CCA via the MCC Certification Application if actuarial value is at least equivalent to a bronze level Connector plan & coverage is determined to be robust and comprehensive.

Auto-Fail

Plans that **auto-fail** due to non-coverage of core services, core services for dependents, or annual dollar caps on prescriptions are **not MCC compliant**; some individuals covered by auto-fail plans may be exempted from a penalty (through Certificate of Exemption or appeal) depending on the situation.

Deemed Non-Compliant

Plans that do not meet all MCC standards and choose to undergo the MCC Certification Application process in an attempt to be deemed compliant may be rejected and **deemed non-compliant** if CCA determines the plan is not robust enough.

Categorically Non-Compliant

Types of plans that the MCC regulations specify as not providing minimum creditable coverage will never be MCC compliant (i.e. a plan issued as a supplemental health insurance policy, Medicare prescription drug plans etc.)

MCC Compliant

Not MCC Compliant

NOTE: The actuarial equivalence provisions under the Regulation do NOT apply to deviations triggering an auto-fail

MCC Deductibles in the Larger Context

		Deductible Limits and Averages	Individual
Health Connector's MCC limits	}	MCC Deductible Limit	\$2,000 (may include \$250 for separate Rx deductible)
Health Connector's shelf		Health Connector's Standard Bronze Plan Deductible	2019: \$2,750 2020: \$2,900
Plans approved by the Health Connector		Plans approved within MCC Certification Application Process (2018)	\$3,516 (average deductible)
National individual market average	}	Average Non-Group ACA Silver Plan Deductible (2019)	\$4,033
National employer averages		Average Small Group Deductibles (2018)	\$2,132
		Average Large Group Deductibles (2018)	\$1,355

Sample Plan Designs within MCC Deductible Limits

Plan Feature/Service		Standard Bronze 2020 64.96%	64.96% AV	61.95% AV
Annual Deductible – Combined		\$2,900	\$2,000	\$2,000
		\$5,800	\$4,000	\$4,000
Annual Deductible – Medical		N/A	N/A	N/A
		N/A	N/A	N/A
Annual Deductible – Prescription Drugs		N/A	N/A	N/A
		N/A	N/A	N/A
Annual Out-of-Pocket Maximum		\$8,150	\$8,150	\$8,150
		\$16,300	\$16,300	\$16,300
Primary Care Provider (PCP) Office Visits		\$30 ✓	\$65 ✓	\$150 ✓
Specialist Office Visits		\$60 ✓	\$85 ✓	\$170 ✓
Emergency Room		\$350 ✓	\$700 ✓	\$1,325 ✓
Urgent Care		\$60 ✓	-	-
Mental/Behavioral health and substance use disorder outpatient services		\$30 ✓	\$65 ✓	\$150 ✓
Inpatient Hospitalization		\$750 ✓	\$1,000 ✓	\$2,500 ✓
Skilled Nursing Facility		\$750 ✓	\$1,000 ✓	\$2,500 ✓
Durable Medical Equipment		20% ✓	20% ✓	20% ✓
Rehabilitative Occupational and Rehabilitative Physical Therapy		\$60 ✓	\$85 ✓	\$170 ✓
Speech therapy		\$60 ✓	\$85 ✓	\$170 ✓
Laboratory Outpatient and Professional Services		\$60 ✓	\$65 ✓	\$65 ✓
X-rays and Diagnostic Imaging		\$75 ✓	\$130 ✓	\$135 ✓
High-Cost Imaging		\$500 ✓	\$1,000 ✓	\$1,000 ✓
Outpatient Surgery: Ambulatory Surgery Center		\$500 ✓	\$500 ✓	\$500 ✓
Outpatient Surgery: Physician/Surgical Services		\$0 ✓	\$0 ✓	\$0 ✓
Prescription Drug	Generics	\$30	\$35	\$35
	Preferred Brand Drugs	\$60 ✓	\$80 ✓	\$150 ✓
	Non-Preferred Brand Drugs	\$125 ✓	\$150 ✓	\$250 ✓
	Specialty Drugs (high-cost)	\$125 ✓	\$150 ✓	\$250 ✓

If plans met current MCC deductible limits

HHS Premium Adjustment Percentage

Indexing from original 2,000/\$4,000 deductible limits using HHS' premium adjustment percentage approach:

Year	HHS Premium Adjustment %	Indexed Deductible Limits
2015	4.21%	\$2,050/\$4,100
2016	8.32%	\$2,150/\$4,300
2017	13.25%	\$2,250/\$4,500
2018	16.17%	\$2,300/\$4,600
2019	25.16%	\$2,500/\$5,000
2020	28.9%	\$2,550/\$5,100

<https://www.federalregister.gov/documents/2016/12/22/2016-30433/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2018>;
2020: <https://s3.amazonaws.com/public-inspection.federalregister.gov/2019-00077.pdf>

Deductible Indexing Methodologies Considered

Staff considered other deductible indexing methodologies:

1. Massachusetts wage growth
2. A Massachusetts-based premium adjustment percentage
3. Potential gross state product (HPC cost growth benchmark)
 - Availability of state level employer premium data and wage data is more difficult to get within the necessary timeline than the federal level HHS premium adjustment percentage published annually and reliably attainable for the timeline needed
 - In addition, some of these methodologies resulted in insignificant changes to deductibles that would pose issues for cost-sharing and fail to address misalignment with current market realities
4. DOI's statutory indexing methodology for HMO products offered with Health Savings Accounts
 - MCC and DOI differ in deductible limits: DOI's statute (M.G.L. c. 176G, §16A) states that, for HMO products, deductibles cannot be greater than the maximum annual contribution to a Health Savings Account (§ 223 of the Internal Revenue Code) when a plan is tied to a Health Savings Account
 - DOI's rule applies to HMOs in Massachusetts while MCC applies to all Massachusetts residents, who may have coverage from all market segments and even from other states
 - If MCC deductible limits were indexed according to DOI's statute, MCC deductibles would have been \$3,500/\$7,000 in 2019
 - This methodology would result in too large of a deductible limit increase at one time, rather than a step-wise approach that moderates the impact to Massachusetts residents over time