

MEMORANDUM

To: Health Connector Board Members
Cc: Louis Gutierrez, Executive Director
From: Andrew Egan, General Counsel
Marissa Woltmann, Director of Policy and Applied Research
Kayla Scire, Policy Analyst
Date: December 6, 2019
Re: Minimum Creditable Coverage Regulations—Public Comment Summary and Adoption of Final Regulations

Health Connector staff will be recommending a final vote on the Health Connector’s proposed amendments to the Minimum Creditable Coverage (MCC) regulations (956 CMR 5.00), inclusive of modest adjustments to the draft regulations the Board released for public comment with a vote at the October 10, 2019 meeting. This memorandum summarizes public comments and testimony related to the Health Connector’s proposed amendments to the MCC regulations and note areas of revision or reconsideration based on the comments received.

BACKGROUND

The Health Connector first promulgated regulations on MCC in 2007 to define the minimum standards a health plan must meet for Massachusetts residents to comply with the requirement to obtain and maintain coverage under the Commonwealth’s “individual mandate” law. While state law defines MCC at a high level, it authorizes the Health Connector’s Board of Directors to promulgate regulations further detailing creditable coverage.¹

The MCC regulations were last updated in 2013 to reflect changes in the health insurance landscape brought by implementation of the federal Affordable Care Act (ACA). Massachusetts chose to maintain its state level individual mandate in large part to maintain the MCC standards, which in addition to providing a minimum “coverage floor” for individual mandate compliance also ensure basic consumer protections for Massachusetts residents.

Since 2013, Health Connector staff have identified several areas of the regulations that would benefit from amendment to better align with market dynamics and current Health Connector practice. Specifically, in October 2019, staff recommended opening a public comment period to receive feedback on three proposed modifications to the regulations:

1) Reinstatement of indexing to deductibles

In 2013, the Board voted to update deductibles annually using the “premium adjustment percentage” calculated by the U.S. Department of Health and Human Services. However, the federal statute cited in the MCC regulations to effectuate the indexing was repealed before taking effect. In addition to repairing this broken indexing cross-reference, the currently proposed amendment would authorize the Board to amend the indexed deductible in any given year via a vote, if it felt appropriate to do so. This will permit the Board flexibility to respond to changes in the landscape, such as any unexpected changes in the federal premium adjustment methodology, if needed to maintain a level approach in Massachusetts.

2) Clarification of standards used to define health arrangements established by religious

¹ M.G.L. 111M § 1; M.G.L. 176Q § 3.

organizations

Currently, the MCC regulations broadly define MCC to include any “health arrangement established by a religious organization comprised of individuals with sincerely held beliefs.” The proposed amendments to the regulation clarify the standards such an arrangement must meet in order to be deemed MCC, in response to the emergence of arrangements that do not comply with ACA requirements or otherwise offer non-comprehensive or fraudulent coverage to consumers under the guise of health arrangements established by religious organizations.

3) Technical and organizational updates

To improve clarity and readability of the regulations, staff updated definitions, removed dated references, clarified the meaning of certain requirements, and reordered provisions.

SUMMARY AND DISCUSSION OF PUBLIC HEARING AND WRITTEN COMMENTS

Overview

The Health Connector accepted comments on the draft MCC regulations from interested parties from October 30, 2019 to November 25, 2019, including in writing and in a public hearing on November 25th. The Health Connector received written comments or testimony from 20 stakeholders and members of the public.² Commenters included carriers, consumer advocates, health arrangements established by religious organizations, and individuals participating in health arrangements.

Commenters were generally amenable to deductible indexing, though some had technical feedback and one suggested further studying the impact on consumers. Commenters also generally recognized the need for additional consumer safeguards for health arrangements established by religious organizations, though some disagreed on the specifics or had concerns about the perceived impact on their organizations. Commenters generally did not comment on technical items so no changes were made. After careful consideration of the comments received, Health Connector staff made some modifications to the text of the proposed regulations, including:

- Additional text around separate prescription drug deductibles to note rounding methodology and that the Board may also vote to override the separate drug deductible (in addition to the indexed medical deductible) in any given year.
- Text confirming that disclosure of financial audits as required by law for certain health arrangements would not be considered inconsistent with the types of health arrangements that may be used to satisfy the individual mandate.
- Modification of language around use of paid agents to ensure health arrangements could continue to rely on referrals by members to grow membership without precluding members from meeting mandate requirements.
- Addition of specific insurance terms that would be considered deceptive in their use outside an insurance product, such as “deductible,” as well as timing and placement of health arrangements’ disclosures.

² The full text of comments and testimony is available upon request.

- Clarification that the “other” criteria the Health Connector may require is only applicable to items necessary to implement the other requirements outlined in the regulation (1)-(6) relating to health arrangements.

The following sections provide a detailed summary of each comment received, Health Connector staff’s response to each comment (with any changes to the proposed regulation noted throughout), and the rationale for each decision.

General

One commenter³ expressed appreciation for eliminating outdated language around allowable benefit limitations and addition of provisions that address the current health insurance landscape. In response to this comment, the Health Connector maintained language as proposed and appreciates confirmation that revisions in this area were clear.

Deductibles

Deductible indexing

Three commenters⁴ were supportive of the reinstatement of deductible indexing, and a fourth⁵ did not outright oppose indexing but had concerns about growing out-of-pocket costs and requested the Health Connector study impacts of this change on plan designs. In response to these comments, Health Connector staff maintained the regulation language as proposed and appreciates recognition from various stakeholders that the current \$2,000/\$4,000 deductible limits are out of step with today’s market. Health Connector staff also appreciated the recognition that out-of-pocket costs are growing and will continue to monitor these costs for consumers.

Deductible indexing methodology

Three commenters⁶ supported the premium adjustment percentage as an indexing factor, and one of those commenters⁷ also supported granting the Board flexibility to adjust the deductible for a given year as needed. Health Connector staff appreciates support for its proposal to rely on the premium adjustment percentage, as well as the flexibility granted to the Board to adjust the deductible for a given year as needed and has maintained the proposed indexing methodology.

Deductible limits

One of the commenters⁸ in support of the premium adjustment percentage methodology suggested maximizing the deductible limits and offered two alternate methodologies. The commenter suggested raising the initial deductible to be indexed to the average deductible approved via the Health Connector’s certification process (\$3,500/\$7,000) and applying indexing from there; or indexing by comparing the “premium adjustment percentage” change

³ Health Care for All (HCFA), Health Law Advocates (HLA)

⁴ BMC HealthNet Plan (BMCHP), Blue Cross Blue Shield of MA (BCBSMA), Massachusetts Association of Health Plans (MAHP)

⁵ HCFA, HLA

⁶ BMCHP, BCBSMA, MAHP

⁷ MAHP

⁸ BCBSMA

since 2007, rather than the federal baseline of 2013. A second supporter⁹ of the premium adjustment percentage methodology asked for clarification about the deductible limit that would be indexed each year.

No changes were made in response to these comments regarding deductible indexing. The Health Connector intends to apply the premium adjustment percentage to the \$2,000/\$4,000 limits in effect in 2013, in the same way indexing is applied to annual out-of-pocket maximums that were in effect in 2013. The premium adjustment percentage itself is calculated to quantify cost changes from a 2013 baseline. Indexing based on change since 2007 as the commenter suggests would require deviating from federal methodology. Using a deductible other than the 2013 baseline would produce skewed results.

Prescription drug deductibles

One commenter¹⁰ questioned whether maintaining the proportion between pharmacy and overall deductibles as it is today is flexible enough to account for the widening gap between total health expenditure growth and pharmacy growth. A second commenter requested that the Health Connector issue guidance each year translating the 12.5% limit to dollar terms to ensure consistency in interpretation and suggested rounding to the nearest multiple of \$50 or \$10. The commenter also requested clarification that the 12.5% limit was only for purposes of the maximum and did not dictate the proportion of any given plan's deductible (e.g., a \$1,000 deductible plan would not be capped at \$125).

Health Connector staff agree with the comment that the separate Rx deductible should be rounded and has added language to reflect that separate Rx deductibles should be rounded down to the nearest \$10 to ensure consistency in interpretation. Health Connector staff also agree that the Board's ability to adjust deductible limits through a vote, if necessary, should apply to both the medical deductible and separate prescription drug deductible and has added language to that end. In addition, regarding the commenter's request for clarification, Health Connector staff agree that the prescription drug deductible is based on the limit in the regulations as indexed and not the specific deductible in a given plan.

Timing of deductible setting

Regarding the timing of setting deductible limits, one commenter¹¹ requested that the Health Connector issue guidance to the market every year no later than March 1 with instructions for the upcoming year. Health Connector staff maintained the language as proposed and agrees with the commenter that annual guidance is necessary and expects to release annual guidance in the March timeframe.

MCC certification

The Health Connector received two comments regarding MCC certification. One commenter¹² suggested amending the regulation to state that Health Connector standard plan designs are automatically MCC compliant, without plans needing to apply for MCC certification if the deductible deviated from regulation. A second¹³ requested that MCC certification be

⁹ BMCHP

¹⁰ BMCHP

¹¹ BCBSMA

¹² BCBSMA

¹³ MAHP

automatic or self-assessed by any plan with an actuarial value that is equal to or greater than the lowest level Bronze product offered by the Health Connector.

Health Connector staff believe that its current process regarding standard plan designs adequately ensures a streamlined process for carriers submitting plans for Seal of Approval. In addition, Health Connector staff does not agree that any plan should be able to meet MCC solely because its actuarial value is equal to or greater than the lowest Bronze product offered by the Health Connector. MCC certification based on actuarial value alone would materially diminish the important consumer protections codified in MCC. For example, if this change was made, a plan that does not cover core services could gain MCC certification if they met the specified actuarial value. In response to these comments, Health Connector staff maintained language as proposed.

Health Arrangements Established by Religious Organizations

General

Ten commenters¹⁴ expressed support for the Health Connector's goal of protecting consumers from entities engaging in fraudulent or deceptive practices while still maintaining a pathway for individuals belonging to legitimate health arrangements to meet MCC requirements. These comments were acknowledged and no changes to the proposed regulations were made. Health Connector staff appreciate recognition from various stakeholders that changes in the market have made additional consumer safeguards necessary.

Several commenters¹⁵ noted that misleading marketing practices have led to consumer confusion and participation in health arrangements under mistaken beliefs about the nature of these products. The commenters noted that this confusion has led to negative health and financial consequences when services consumers thought would be covered are not. Health Connector staff acknowledge these comments and agree that misleading marketing practices have led to negative consequences for consumers. No changes were made in response to these comments.

Twelve commenters¹⁶ expressed concerns that the Health Connector was seeking to remove some individuals' preferred pathway to individual mandate compliance. Specifically, commenters noted that, in their experience, health arrangements provided for individuals' medical needs while being more affordable than insurance products and honored religious and community-based principles. Others noted that they experienced fewer administrative burdens than insurance alternatives, which commenters stated have less provider choice and often require pre-authorizations. Health Connector staff appreciate the concern commenters expressed and the reasons why some consumers may prefer their health arrangements over insurance alternatives. Health Connector staff affirm that health arrangements may continue to be a pathway for individuals to satisfy the individual mandate and made no changes to the proposed regulation in response to these comments because they did not recommend specific adjustments.

Exemption from MCC

¹⁴ Members of the public, MA Attorney General's Office, Samaritan Ministries International, Christian Care Ministry, Alliance of Health Care Sharing Ministries, BCBSMA, MAHP, HCFA, HLA

¹⁵ MA Attorney General's Office, MAHP, HCFA, HLA

¹⁶ Members of the public, Alliance of Health Care Sharing Ministries

Several commenters¹⁷ expressed a desire for the Health Connector to maintain a categorical individual mandate exemption for members of health arrangements and some commenters opposed new requirements for health arrangements. In response to these comments, Health Connector staff affirm that membership in a health arrangement can continue to meet MCC standards. For clarity, such arrangements satisfy the individual mandate if they meet the proposed standards rather than form the basis for an exemption from the mandate. MCC regulations outline the kinds of coverage an individual must have to satisfy the mandate. They do not require market actors to provide compliant coverage. No changes were made to the regulations in response to these comments.

Right of conscience and religious exercise

One commenter¹⁸ expressed concerns that the proposed regulations abridge individual right of conscience and religious exercise. The Health Connector's proposed regulations do not in any way affect an individual's ability to freely exercise their rights to religion and conscience. The proposed regulations ensure that individuals can satisfy the individual mandate through legitimate health arrangements, while safeguarding individuals from fraudulent or misleading entities. Further, individuals can continue to claim the religious exemption available in the individual mandate, if appropriate, since that exemption is not addressed or affected by these regulations. Alternatively, individuals can become members of health arrangements, consistent with these regulations, without being subject to a mandate penalty. For clarity, being exempt from the individual mandate based on a religious belief is different from satisfying the individual mandate by being a member of a health arrangement.¹⁹ No changes were made to the regulations in response to this comment.

Health arrangement definition

Two commenters²⁰ suggested that the Health Connector define a health arrangement consistent with the federal definition of a "health care sharing ministry (HCSM)" in 26 U.S.C. 5000A(d)(2)(B). Health Connector staff believe that the federal definition of an HCSM does not contain adequate consumer protections. Further, it is Health Connector staff's understanding that the federal government is no longer actively monitoring HCSMs or determining which HCSMs satisfy federal standards. Massachusetts has maintained its own individual mandate since 2006, including after 2014 despite the addition of the federal mandate at that time. The state chose to preserve its own individual mandate specifically to keep in place the MCC standards that meet the needs of Massachusetts and its residents, including addressing any shifts in the Massachusetts coverage landscape, such as the recent uptick of health arrangements that are operating troubling in new ways. Based on these reasons, Health Connector staff did not make any changes to the proposed regulations in response to these comments.

Not for-profit status

¹⁷ Members of the public

¹⁸ Liberty Share

¹⁹ See 830 CMR 111M.2.1(6)(b)

²⁰ Christian Care Ministry, Alliance of Health Care Sharing Ministries

Two commenters²¹ supported requiring that the organization be not for-profit. One of these commenters²² suggested affirmatively requiring that the organizations be registered as 501(c)(3) non-profit organizations. Health Connector staff appreciate commenters' support for requiring individuals to only belong to health arrangements that are not for-profit in order to meet MCC. However, Health Connector staff do not believe arrangements that are not for-profit are always registered as 501(c)(3)s and does not want to limit the corporate forms of health arrangements individuals may have in order to satisfy the mandate. Health Connector staff did not make any changes in response to these comments.

Representation of financial soundness

One commenter²³ supported the restriction on making representations about financial soundness. Three commenters²⁴ suggested removal of this provision because they stated that they are required by law to disclose financial statements as tax-exempt entities and believed that this would conflict with the proposed restriction on making representations about financial soundness. Health Connector staff appreciate support for the requirement in this provision and does not agree that disclosure of financial statements, including those required by law, by a health arrangement would preclude a member from satisfying the individual mandate. However, in order to avoid confusion, we have amended the regulations to specify that the provision does not apply to required financial disclosures.

Compensated agents and sales tactics

Four commenters²⁵ generally opposed restrictions on health arrangements considered MCC using compensated agents. Of the commenters in opposition, one commenter²⁶ requested specifying "licensed" agents as those prohibited from being used by health arrangements. Two of these commenters²⁷ requested that the regulations rely on Massachusetts's consumer protection law (M.G.L. Ch. 93A). One of these commenters also noted concern that the language could be interpreted as prohibiting incentives for member referrals. Health Connector staff disagree that the restriction on using compensated agents should be narrowed to only "licensed" agents because the use of sales agents generally indicates that a given operation is functioning more as a business, rather than as a sharing arrangement among a community of individuals with sincerely held religious beliefs. This blurs the distinction between such sharing arrangements and regulated health insurance and creates space for fraudulent enterprises to operate. Health Connector staff also disagree that this provision should rely solely on Ch. 93A to achieve its intended goal of consumer protection because MCC is separate from 93A. The MA Attorney General would determine whether specific conduct violates 93A, which might include the kinds of deceptive marketing prohibited by these rules. Our guidelines are tailored to the individual mandate context. In order to address concerns that the proposed language is too broad and may have unintended consequences, Health Connector staff changed the proposed regulations to specify that the prohibited compensated agents were specifically "sales agents," which

²¹ MA Attorney General's Office, Samaritan Ministries International

²² Samaritan Ministries International

²³ MA Attorney General's Office

²⁴ Samaritan Ministries International, Christian Care Ministry, Alliance of Health Care Sharing Ministries

²⁵ Members of the public, Samaritan Ministries International, Christian Care Ministry, Alliance of Health Care Sharing Ministries

²⁶ Samaritan Ministries International

²⁷ Christian Care Ministry, Alliance of Health Care Sharing Ministries

would not include member referrals so long as such referrals do not constitute sales conduct.

One commenter²⁸ stated that restrictions on paid agents help to ensure that health arrangements are legitimately operating among individuals with sincerely held beliefs and reduce deceptive practices and deceptive marketing. This commenter also suggested additional language to prohibit the use of common insurance terms that would help to further make clear the type of deceptive behavior the proposed regulations seek to prohibit. Health Connector staff agree that the proposed regulations about paid agents will help to reduce deceptive practices to protect consumers and agrees that prohibiting the use of specific insurance terms will also help to effectively prevent deceptive marketing practices. In response to this comment, Health Connector staff added the commenter's suggested language to prohibit the use of specific insurance terms such as "deductible" or "premium."

Use of funds for administrative costs

Related to the use of members' medical cost contributions for administrative costs, three commenters²⁹ suggested annually disclosing administrative fees and costs to participants instead of the proposed restriction. The proposed restriction would prevent funds paid by members for medical costs to go toward a health arrangement's administrative costs for a health arrangement to be useful in satisfying MCC. Health Connector staff disagree that disclosure of administrative fees is equivalent to ensuring that members' contributions specifically for medical costs within the arrangement do not go toward administrative costs instead. A health arrangement that applies funds paid for medical costs to administrative costs instead may mean that less money is available to pay for medical costs, exposing consumers and providers to uncompensated care—an outcome inconsistent with the goals of the mandate and MCC. For clarity, health arrangements may charge a separate administrative fee and still be used by MA residents to satisfy MCC. For these reasons, no changes were made to the proposed language.

One commenter³⁰ expressed support for prohibiting health arrangements to be used by MA residents to satisfy MCC from directing member funds for covering health care costs to their own administrative expenses. This commenter noted that in one case, a health arrangement used 70% of every dollar collected from its members toward the organization and its own profits instead of member medical costs. Health Connector staff appreciate recognition from the commenter that this proposed regulation is necessary to prohibit member shares for medical costs going to administrative costs. No changes were made in response to this comment.

Required Disclosures

Four commenters³¹ supported the proposed regulation for health arrangements to be used by MA residents to satisfy MCC to provide a written disclosure that the organization is not an insurance company and does not guarantee that medical bills will be paid by the organization

²⁸ MA Attorney General's Office

²⁹ Samaritan Ministries International, Christian Care Ministry, Alliance of Health Care Sharing Ministries

³⁰ MA Attorney General's Office

³¹ MA Attorney General's Office, Samaritan Ministries International, Christian Care Ministry, Alliance of Health Care Sharing Ministries

or any other individuals. One³² of these four supporters proposed additional clarifying language about when the disclosure occurred and in what materials. Two supporters³³ requested that the Health Connector provide specific language for the disclosure. Health Connector staff agree that more specificity about when and where the disclosure occurs is important to add and incorporated these suggestions. Specifically, Health Connector staff included the suggestions that 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. Health Connector staff declined to adopt a scripted disclosure for all health arrangements at this time. Similar to other portions of MCC, Health Connector staff believe it is more appropriate to promulgate a standard at this time and allow health arrangements to create their own language that works best for their organization, so long as it meets the standard.

Reporting Requirement

Five commenters³⁴ expressed overall support for reporting of information by health arrangements. However, commenters differed on what the reporting requirements should entail. One commenter generally supported the requirement as drafted. Two commenters³⁵ indicated that they would support a registration process similar to a Memorandum of Understanding (MOU) that the Oklahoma Division of Insurance and certain health arrangements have created. One commenter³⁶ stated that the reporting requirements as drafted are too vague and should be more specifically defined in the regulation. Health Connector staff appreciate support for the requirement for health arrangements to report certain information annually. Health Connector staff will consider the MOU elements when implementing the reporting requirement but declined to adopt the specific elements enumerated in the Oklahoma MOU in its regulations. Health Connector staff disagree that the reporting requirements should be based off the Oklahoma MOU registration process since the Health Connector serves a different function than a Division of Insurance and will not be registering entities. The reporting requirement does not carry any further legal significance beyond meeting MCC. In response to these comments, Health Connector staff made no changes to the proposed language.

Other Criteria

Three commenters³⁷ opposed the requirement that entities meet other criteria deemed appropriate to ensure members participating in a health arrangement have access to health care services in a manner consistent with the purpose of Ch. 111M. One of these commenters³⁸ noted that this was beyond the Health Connector's authority and violated Massachusetts Administrative Procedure Act. The Health Connector agrees that it is subject to the Massachusetts Administrative Procedure Act and would not take any action out of compliance with its rules and limitations. However, in order to clarify the intent of this proposed language, Health Connector staff clarified in the proposed regulation language that

³² MA Attorney General's Office

³³ Alliance of Health Care Sharing Ministries, Christian Care Ministry

³⁴ MA Attorney General's Office, Samaritan Ministries International, Christian Care Ministry, Alliance of Health Care Sharing Ministries

³⁵ Christian Care Ministry, Alliance of Health Care Sharing Ministries

³⁶ Alliance of Health Care Sharing Ministries

³⁷ Samaritan Ministries International, Christian Care Ministry, Alliance of Health Care Sharing Ministries

³⁸ Samaritan Ministries International

this provision is only applicable to items necessary to implement the other requirements outlined in the regulation (1)-(6).

One commenter³⁹ expressed support for the Health Connector to include additional criteria to evaluate whether a health arrangement can be deemed minimum creditable coverage. Health Connector staff appreciate recognition that additional criteria may be necessary and made no changes in response to this comment.

CONCLUDING REMARKS

In summary, Health Connector staff appreciate the thoughtful comments and testimony received on the proposed MCC regulation amendments. After careful consideration of and response to each comment, Health Connector staff believe that the clarifications and revisions incorporated into the regulations reflect important feedback from stakeholders and the public.

MCC regulations are intended to ensure basic consumer protections while also retaining affordability. Health Connector staff believe that the final version of proposed MCC regulations strike this balance.

If the Board votes to approve the final version of the proposed regulations on December 12, the Health Connector will file the final regulations with the Secretary of State on December 13. The adopted final version of the proposed regulations would then be published in the Code of Massachusetts Regulations (CMR) on December 27 with a January 1, 2020 effective date.

³⁹ MA Attorney General's Office