

Administrative Bulletin 02-10

Guidance Regarding Minimum Creditable Coverage (MCC) Certification

May 6, 2010

The purpose of this Administrative Bulletin is to provide guidance regarding certain provisions of the Commonwealth Health Insurance Connector Authority's ("Health Connector") Minimum Creditable Coverage ("MCC") regulation, 956 CMR 5.00, ("Regulation") as adopted by the Health Connector's Board of Directors on 12-10-2009.

1. Prohibition Against Overall Annual Dollar Benefit Maximum on Prescription Drugs

Effective on and after January 1, **2011**, section 956 CMR 5.03(2)(f)3 of the Regulation prohibits a health benefit plan from placing an overall annual dollar cap on the amount of prescription drug coverage provided to a covered person. Prescription drug coverage may continue to be subject to the overall plan deductible (not to exceed \$2,000 for individual coverage nor \$4,000 for family coverage); a separate prescription drug deductible (not to exceed \$250 for individual coverage nor \$500 for family coverage); and/or cost-sharing (whether in the form of co-insurance or copayments). The prohibition of an overall annual dollar limit on a health benefit plan's prescription drug benefit is not intended, and will not be interpreted, to prevent or interfere with a carrier's or plan sponsor's discretion to manage its prescription drug formulary. A health benefit plan may utilize different tiers of prescription drug coverage or have different levels of cost-sharing for different tiers of prescription drugs (e.g., generic, preferred-brand, non-preferred-brand). In addition, this provision does not prohibit a plan from excluding or limiting certain types of prescription medication, though the Health Connector reserves the authority to deny MCC Certification to any plan that contains, in its discretion as provided in the Regulation, excessive exclusions or limitations.

Any health benefit plan with overall annual dollar caps on prescription drug coverage is not eligible for MCC Certification. If submitted to the Health Connector, such a plan will be denied MCC Certification automatically. The actuarial equivalence provisions under the Regulation do NOT apply to this type of deviation.

2. Coverage for All "Broad Range of Medical Benefits" to Be Extended to All Covered Persons

Effective on and after January 1, **2011**, section 956 CMR 5.03(3) requires that all core services and "broad range of medical benefits" covered under a health benefit plan be

provided to all persons covered under that plan. Therefore, a health benefit plan that provides dependent coverage must provide coverage for all core services and “broad range of medical benefits” in accordance with the Regulation to all covered dependents as provided to the subscriber. This provision is designed, in part, to ensure that a health benefit plan that covers dependents extends coverage for maternity services to the pregnant daughter of the subscriber.

Any health benefit plan that provides dependent coverage, but that does not provide to dependents coverage as described in the above paragraph, is not eligible for MCC Certification. If submitted to the Health Connector, such a plan will be denied MCC Certification automatically. The actuarial equivalence provisions under the Regulation do NOT apply to this type of deviation.

3. Federally-Qualified, Health Savings Account-compatible High Deductible Health Plans (HDHPs)

Under the Regulation for calendar year **2009**, HDHPs that met the specific federal requirements of Internal Revenue Code section 223 were considered federally-qualified, HSA-compatible, and were deemed to meet MCC standards automatically in accordance with section 956 CMR 5.03(2)(k)1 of the Regulation.

Effective on and after January 1, **2010**, the Regulation requires federally-qualified, HSA-compatible HDHPs to meet specified aspects of MCC (to the extent the MCC provisions are not inconsistent with federal requirements for these HDHPs) except that they may have deductibles and out-of-pocket maximums that differ from MCC. If a federally-qualified, HSA-compatible HDHP:

- a. complies with section 223 of the Internal Revenue Code (IRC);
- b. meets specified MCC standards (sections 956 CMR 5.03(2)(a), (f), (g), and (h) of the Regulation);
- c. has deductibles and out-of-pocket maximums within the range permitted under section 223 of the IRC; and either
- d. the carrier or plan sponsor facilitates access to an HSA or
- e. the plan sponsor establishes and maintains an HRA;

then the carrier or plan sponsor may self-certify that the HDHP meets MCC. Therefore, an HDHP that meets the requirements above should NOT be submitted to the Health Connector for MCC Certification.

Any combination of a non-HSA-compatible HDHP and an HRA must meet all aspects of MCC, including deductibles and OOP maximums (after taking into account the HRA).

HDHP/HRA combinations that do not meet all aspects of MCC should be submitted to the Health Connector for MCC Certification.

4. Preventive Care Cost-Sharing

A health benefit plan may charge a higher copayment or co-insurance for specialist office visits for preventive care than it does for primary care office visits for preventive care and still satisfy the preventive care provisions of the Regulation under section 956 CMR 5.03(2)(h). A health benefit plan's cost-sharing for preventive care must be consistent with cost-share for the office visit at the point of service. For, example, if the cost-share for an office visit at a primary care provider is \$10 and the cost-share for an office visit at a specialist is \$20, then the cost share used for preventive care services cannot exceed those levels for the corresponding provider type. Please note, if a well-woman exam is performed by a PCP, then the PCP cost share should be used. If a well- woman exam is performed by a specialist (OB/GYN), then a specialist cost-share may be used.

5. MCC Certification Application Process

The Health Connector will continue to accept and review MCC Certification Applications for health benefit plans that **deviate** from any of the MCC standards established under the Regulation, as identified by plan sponsors. Please note that the MCC Certification Application process is reserved for plans that deviate from the MCC standards with the burden on plan sponsors to identify any such deviations. The Health Connector will NOT conduct general compliance reviews of health benefit plans to determine whether such plans deviate from the Regulation. In addition, the Health Connector will neither review nor take any action on applications that do not identify the health benefit plan's deviation(s). Applications that do not identify the health benefit plan's deviation(s), that do not provide all the benefit and cost-sharing information requested in the Application, or that do not attach a schedule of benefits will be considered incomplete and will not be processed.

Health benefit plans submitted to the Health Connector for MCC Certification must:

- a. provide coverage for all core services without any overall annual dollar or visit limitation on any category of core services¹;
- b. provide coverage for prescription drugs without any overall annual dollar cap (a plan that does not cover prescription drugs or, effective on and after January 1,

¹ Core services consist of physician services, inpatient acute care services, day surgery, and diagnostic procedures and tests.

- 2011, a plan that places an overall annual dollar cap on prescription drug coverage will be denied certification);
- c. provide some level of coverage for all categories within a “broad range of medical benefits” as identified in section 956 CMR 5.03(2)(a)2 (a plan that fails to provide any level of coverage for any one or more of the categories of “broad range of medical benefits” will be denied certification);
 - d. effective on and after January 1, 2011, provide all covered services to all covered persons under the plan if the plan covers dependents (e.g., a plan that does not cover maternity services for the pregnant daughter of a subscriber will be denied certification);
 - e. be actuarially equivalent to, or better than, the 2010 Bronze low level coverage offered through the Health Connector’s Commonwealth Choice program (**the fact that a plan is actuarially equivalent to Bronze does NOT automatically make the plan MCC compliant or MCC Certified**);
 - f. deviate from the MCC standards in some way.

The Health Connector reserves the authority to deny MCC Certification to any plan that contains, in its discretion as provided in the Regulation, excessive exclusions or limitations.

DEADLINE: The deadline for Applications seeking certification for the 2010 calendar year is November 30, 2010. Any Application received after November 30, 2010 will not be processed for 2010 certification.

6. Resubmission of Plans Previously Certified for MCC

- a. Plans that received MCC Certification for 2009-only (and did not receive certification beyond December 31, 2009) may be resubmitted to the Health Connector for review to determine whether MCC Certification for 2010 will be granted.
- b. For plans that received MCC Certification beyond December 31, 2009, if a plan design change affecting an MCC standard is made to such a health benefit plan, and the plan design change:
 - i. Expands or increases an existing deviation or creates a new deviation, then the plan sponsor should send an e-mail to MCC.Certification@state.ma.us that includes the plan’s MCC Certification number previously provided by the Health Connector and identify the plan design change. In addition, the plan sponsor should

provide a schedule/summary of benefits that reflects the identified change. For example, if a plan with a \$2,500 individual and \$5,000 family deductible (MCC deductible limits are \$2,000/\$4,000) that was previously MCC certified by the Health Connector increases its deductibles to \$3,000 individual and \$6,000 family, then it should be resubmitted to the Health Connector for review.

- ii. Reduces or eliminates an existing deviation, then the plan need not contact the Health Connector. For example, if a plan with a \$2,500 individual and \$5,000 family deductible that was previously MCC certified by the Health Connector, reduces its deductibles to \$2,100 individual and \$4,200 family (or \$1,800 individual and \$3,600 family), then it should NOT be resubmitted to the Health Connector for review.

7. Health Benefit Plans Subject to a Collective Bargaining Agreement

The regulatory flexibility for group health plans that are maintained pursuant to a collective bargaining agreement that was in effect on January 1, 2009, or that is part of a Multi-employer Health Benefit Plan will continue to be available. MCC Certification for these plans and/or a grace period to comply with MCC is at the Health Connector's discretion. **The fact that a plan is subject to a collective bargaining agreement does NOT automatically make the plan MCC compliant.**

Collectively bargained plans that have been certified until a specific date should contact the Health Connector at least three (3) months prior to the expiration of the certification so that MCC status can be re-evaluated.