Administrative Bulletin 01-13:
Guidance Regarding Minimum Creditable Coverage (MCC) Regulations
On and After January 1, 2014
May 6, 2013

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).

I. Maximum Out-of-Pocket (MOOP) Safe Harbor Provision

Section 5.03(1)(e) of the MCC Regulations requires that for plan or policy years beginning on or after January 1, 2014, a health benefit plan's calculation of the MOOP must include any expenditure, including deductibles, co-insurance, co-payments, or similar charges, on behalf of an enrollee with respect to Essential Health Benefits (EHBs). The regulations further specify that the MOOP for in-network covered services, or the sum of MOOPs for in-network covered services, must not exceed the limits specified in Section 5.03(1)(d) of the MCC Regulations .

For purposes of providing issuers and plan sponsors additional time necessary to address operational concerns associated with this requirement, the Health Connector will provide plan sponsors or health insurance issuers providing group health plans a transitional safe harbor provision. This aligns with the federal approach for implementation of the cost-sharing limits introduced by the Affordable Care Act (ACA). Consistent with the sub-regulatory guidance issued by the Department of Health and Human Services (HHS), the U.S. Treasury, and the Department of Labor (DOL)[1], this safe harbor provision is only available for the first plan year beginning on or after January 1, 2014. In addition, this safe harbor provision is only available in instances where a plan sponsor or health insurance issuer offering group coverage utilizes more than one service provider to administer benefits that are considered EHBs and therefore for which the enrollee's expenditures must accumulate toward the MOOP.

Under this one-year safe harbor provision, the Health Connector will consider the MCC MOOP requirement to be satisfied if both of the following conditions are satisfied:

1) The plan complies with the MOOP requirements with respect to its major medical coverage (excluding, for example, prescription drug coverage and pediatric dental coverage); and
2) To the extent the plan or any health insurance coverage includes a MOOP on coverage that does not consist solely of major medical coverage (for example, if a separate MOOP exists for prescription drug coverage), such MOOP does not exceed the dollar amounts set forth in section 5.03(1)(d) of the MCC Regulations.

In summary, this safe harbor provision requires a plan to have a MOOP for its major medical coverage, which would include most EHBs. If the plan currently has a separate MOOP for non major medical coverage that is an EHB (e.g., prescription drug coverage), that MOOP, considered on its own, cannot exceed the MOOP limits identified in section 5.03(1)(d) of the MCC Regulations. If a health plan does not currently have a MOOP on this component of coverage, it is not required to institute a MOOP for this coverage. In either of these circumstances, the "actual" allowable MOOPs, if combined, would be greater than that which the MCC regulations would otherwise allow. This is only allowable for the first

[1] See http://www.dol.gov/ebsa/faqs/faq-aca12.html

plan year beginning on or after January 1, 2014; subsequently, the MOOP or combined MOOPs for all EHBs in a medical plan must sum to no more than that which is allowed in section 5.03(1)(d) of the MCC Regulations.

II. MOOP Requirements and Standalone Dental Plans

As stated above, Section 5.03(1)(e) of the MCC Regulations requires that for plan or policy years beginning on or after January 1, 2014, a health benefit plan's calculation of the MOOP must include any expenditure, including deductibles, co-insurance, co-payments, or similar charges, on behalf of an enrollee with respect to EHBs. The regulations further specify that the MOOP for in-network covered services, or the sum of MOOPS for in-network covered services, must not exceed the limits specified in Section 5.03(1)(d) of the MCC Regulations .

The language included in these regulations is intended to apply to a health benefit plan's calculation of a MOOP; specifically, this language clarifies that all enrollee costs for EHBs must count toward the MOOP. Therefore, a health benefit plan that includes embedded pediatric dental benefits, which are considered a component of the EHB package, would be required to accumulate any applicable cost-sharing for pediatric dental services as part of the plan's MOOP. However, the MCC Regulations do not require individuals to have an insurance plan that includes dental coverage. In an instance where an individual has separate medical and dental plans, the MCC regulations do not require the MOOPs for these distinct plans to sum to the limits specified in Section 5.03(1)(d) of the MCC Regulations. This is true even if the medical and dental plans are "bundled." Consistent with the federal approach for implementing the cost-sharing requirements introduced by the ACA as codified in 45 CFR 156.130, the MCC Regulations continue to allow dental plans to have an annual limitation on cost-sharing that is separate from medical plans covering the remaining EHBs.