

Administrative Bulletin 02-13

Guidance Regarding Minimum Creditable Coverage (MCC) Certification

October 2, 2013

The purpose of this Administrative Bulletin is to provide guidance regarding certain provisions of the Commonwealth Health Insurance Connector Authority's ("Connector") Minimum Creditable Coverage ("MCC") regulation 956 CMR 5.00 ("Regulation"). This Bulletin supersedes and replaces Administrative Bulletin 01-08.

What are an employer's obligations?

Under the Massachusetts Health Care Reform Law, employers and plan sponsors are not required to provide coverage that meets the Health Connector Board's MCC standards. However, employers, plan sponsors and carriers are required to provide a written statement, known as a 1099-HC, annually to each subscriber or covered individual residing in the Commonwealth to whom they have provided minimum creditable coverage in the previous calendar year. Therefore, carriers, employers, and plan sponsors will need to determine if their health benefit plans satisfy the MCC standards. In addition, carriers are required to disclose the MCC status of their fully insured health benefit plans sold in the Commonwealth of Massachusetts. Self-insured plans and fully insured plans that are not sold in Massachusetts, on the other hand, are not required to provide such an MCC disclosure.

Self-assessment.

The Health Connector expects that carriers, employers, and plan sponsors will self-assess and determine whether their plans meet the MCC standards set forth in the Regulation. If you determine that your plan meets MCC standards set forth in the Regulation, you do not need to seek any form of approval or certification from the Health Connector. The majority of health benefit plans will fall into this self-assessment category.

MCC Certification by the Health Connector.

The Regulation (956 CMR 5.03(3)(g)) provides the Health Connector with discretion to deem health benefit plans that deviate modestly from the MCC standards as providing minimum creditable coverage if the plans can demonstrate they meet certain criteria. This process will be referred to as MCC Certification and is designed to provide plans a way to comply with MCC standards in instances in which a plan does not meet every element of the Regulation. An employer, plan sponsor, or carrier seeking to have a plan deemed MCC compliant via this alternative to self-assessment must complete an MCC Certification Application.

The Health Connector's MCC Certification Application requests information that the Health Connector believes is necessary to make a determination on the Application as expeditiously as possible. In cases where the Health Connector does not receive sufficient information with the

Application, the Health Connector will request additional information so that it has the necessary information with which to make a determination.

An applicant for MCC Certification must provide the plan's schedule of benefits, identify the plan's deviations from the MCC standards, and provide additional information supporting his/her application. The Health Connector will review the materials provided by the applicant and will grant an MCC Certification if, in its discretion, it determines that the overall value of the benefits provided by the plan, despite the deviations identified by the applicant, provides sufficiently comprehensive coverage.

MCC Standards

In order to be eligible to apply for MCC Certification by the Health Connector, the health benefit plan must comply with the provisions of 956 CMR 5.03(3)(a)7. Or 5.03(3)(b)6.; this means that a plan must:

- Provide coverage for all core services¹ (i.e., physician services, inpatient acute care services, day surgery, and diagnostic procedures and tests) defined in the Regulation; and
- Provide some level of coverage for each of the broad range of medical benefits listed in 956 CMR 5.03(1)(a).
 - Ambulatory patient services, including outpatient, day surgery and related anesthesia;
 - Diagnostic imaging and screening procedures, including x-rays;
 - Emergency services;
 - Hospitalization (including at a minimum, inpatient acute care services which are generally provided by an acute care hospital for covered benefits in accordance with the member's subscriber certificate or plan description);
 - Maternity and newborn care, including prenatal care, postnatal care, and delivery and inpatient services for maternity care;
 - Medical/surgical care, including preventive and primary care;
 - Mental health and substance abuse services;
 - Prescription drugs;
 - Radiation therapy and chemotherapy.
- Have an actuarial value equal to or greater than any Bronze-level plan offered through the Health Connector.

For the period beginning January 1, 2010, a health benefit plan will not be granted an MCC Certification if:

¹ The Regulation prohibits an overall annual limit on core services collectively or individually by category. A health benefit plan may place limitations, however, on certain services within each category of core services. Nothing in the Regulation should be construed to restrict a plan sponsor's or carrier's ability to apply utilization management tools, such as pre-approval, prior authorization, closed prescription drug formularies, etc.

- Benefit limitations established by the health benefit plan are clearly inconsistent with standard employer-sponsored coverage; and
- Benefit limitations established by the health benefit plan (that are inconsistent with standard employer-sponsored coverage) do not represent innovative ways to improve quality or manage the utilization or cost of services delivered.

Deviations from MCC standards.

A health benefit plan that deviates from the specified elements of the Regulation but meets the criteria above may apply to the Health Connector for MCC Certification. Some examples of deviations for which a plan may seek MCC Certification are:

- Coverage of preventive care services which deviates from the pre-deductible or nationally recognized standard requirements stipulated in the Regulation;
- Deductible amount(s) which exceed the limits set forth by Regulation or which are applied in a different manner than contemplated in the Regulation;
- Maximum out-of-pocket amount(s) which exceeds the limits set forth by Regulation or which are applied in a different manner than contemplated in Regulation.

The above examples are purely illustrative and do not constitute an exhaustive list of deviations for which a health benefit plan may seek MCC Certification.

When must a health benefit plan provide an actuarial attestation?

MCC Certification requires the overall value of a plan seeking MCC Certification to be equal to or greater than any Bronze-level plan offered through the Health Connector. Applicants will be required to state whether they believe that the health benefit plan in question meets this standard, and may eventually be required to submit an actuarial attestation with the initial application.

The Health Connector has the sole discretion to request an actuarial attestation from an applicant in order to determine whether the health benefit plan meets the Health Connector's MCC standards. If the Health Connector cannot readily determine from a review of the initial application that the health benefit plan meets the actuarial standard, then the Health Connector is likely to request an actuarial attestation.

What is actuarial equivalence?

The actuarial value, typically expressed as a percent or fraction, is calculated based on the expected medical claims cost to the health plan to provide that health plan's benefits to a standard population. The value would take into account member cost-sharing. The actuarial value would also take into account any expected reduction in utilization caused by the presence of cost sharing that might cause a member to pursue care for certain conditions.

Two plans are considered to be actuarially equivalent if they have the same or closely similar actuarial value. Therefore the Health Connector will consider a plan to be actuarially equivalent to a Bronze-level plan if the applicant's plan has an actuarial value of at least 100% of any Health Connector Bronze-level plan.

Aggregating Multiple Plans

Under 956 CMR 5.03(1)(i) or 5.03(2), an individual may combine multiple plans in order to meet MCC. The Regulation provides the following examples:

- A health benefit plan that excludes prescription drug coverage may be combined with a separate prescription drug only health benefit plan so that, together in the aggregate, the combined health benefit plans satisfy 956 CMR 5.03(1)(c)3.
- A health benefit plan that excludes coverage for mental health services may be combined with a separate mental health carve-out so that, together in the aggregate, the combined health benefit plans satisfy the standards of minimum creditable coverage.

As an employer or plan sponsor, if the health coverage provided is made up of multiple health benefit plans, you should combine the features and determine the aggregate value of the plans in assessing whether, as a whole, the health coverage meets MCC standards. If the plan you are submitting for MCC Certification is composed of several plans (e.g., certain benefits are carved out), you must provide information for all plans that make up your health coverage. Any actuarial attestation submitted must attest to the value of the combined health plans, but need not assess the value of each separate benefit (e.g., medical, mental health/substance abuse, prescription drugs).

Effective Date of an MCC Certification

A health benefit plan's MCC Certification from the Health Connector is valid until there is a material change to the benefits provided by the plan and/or the Health Connector Board approves revisions to the Regulation that alters MCC standards. A material change is defined as a modification to a plan's benefit design (e.g., a change in covered benefits and/or cost sharing) that relates directly to MCC standards. Material changes to the plan of benefits and/or cost sharing that do not impact MCC standards (e.g., the elimination of acupuncture coverage, changes to cost sharing for durable medical equipment, an increase in co-insurance for out-of-network coverage, etc.) would not require a plan sponsor or carrier to request MCC re-certification. If a plan does have a material change, a plan sponsor or carrier should re-apply for MCC Certification.

The Connector will work with the applicant if there are any questions with respect to the effective date or duration of the plan's MCC Certification.

The Health Connector reserves the right to withdraw a plan's MCC Certification if the Health Connector subsequently determines that any of the underlying facts, information, or

circumstances are materially inconsistent with the representations and documents submitted in support of the MCC Certification Application.

Mental Health and Substance Abuse Services

For purposes of the Regulation, mental health and substance abuse services are not considered core services. Mental health and substance abuse services are considered part of the broad range of medical services required to be covered, but a health benefit plan may place limitations as permitted by the Regulation.

In order to meet MCC standards, health benefit plan limitations on mental health and substance abuse services must be consistent with applicable state and federal mental health parity requirements. The MCC Regulation neither exempts nor interferes with a plan's obligation to comply with state and federal laws to which it is subject.

Maximum Out-of-Pocket (MOOP)²

If the health benefit plan's MOOP is calculated without including the deductible, a health benefit plan will satisfy the provisions of 956 CMR 5.03(1)(d) if the plan's MOOP for in-network covered services, when combined with the plan's deductible for in-network covered services, does not exceed \$5,000 for an individual and \$10,000 for a family.

If a health benefit plan includes co-insurance on core services³ or an overall deductible but does not include an explicit MOOP for in-network covered services, it may still satisfy the provisions of 956 CMR 5.03(1)(d) if the member's out-of-pocket exposure would not exceed \$5,000 for an individual and \$10,000 for a family.

High Deductible Health Plans (HDHPs)

In order to meet MCC, an HDHP must be compliant with 26 U.S.C. § 223, must cover core services, must cover a broad range of medical benefits, and must facilitate access to an HSA or establishes and maintains an HRA. For purposes of MCC, "facilitate access to an HSA" means the plan sponsor and/or carrier must provide information to the policyholder explaining an HSA and how an individual may establish and fund an HSA if he/she so chooses. The Regulation does not require an individual to establish or fund an HSA.

Generally, an HDHP that is consistent with federal requirements under 26 U.S.C. § 223 may only deviate from the requirements of MCC with regard to its deductibles and its MOOPs. An HDHP otherwise must meet the requirements of the Regulation to the extent that such requirements are not inconsistent with federal statutory and regulatory requirements under 26 U.S.C. § 223.

² This provision does not supersede Administrative Bulletin 01-13. Health insurance issuers and plan sponsors may still use the transitional safe harbor if applicable.

³ Core services consist of physician services, inpatient acute care services, day surgery, and diagnostic procedures and tests.

Collectively Bargained Plans

A group health plan that is maintained pursuant to a collective bargaining agreement in effect on January 1, 2009, or that is part of a Multi-employer Health Benefit Plan that cannot self-assess as being MCC compliant may apply to the Health Connector for MCC Certification. Section 956 CMR 5.03(5) of the Regulation does not constitute an automatic safe harbor. In accordance with section 956 CMR 5.03(5), the Health Connector, in its discretion, after reviewing the totality of the circumstances of a particular request for MCC Certification, may grant MCC Certification for up to one year following the expiration of a collectively bargained agreement that is in effect on January 1, 2009, or, if part of a Multi-employer Health Benefit Plan, up to one year following the date of the last renewing collectively bargained agreement that is part of the Multi-employer Health Benefit Plan. This “grace period” is intended to allow the parties subject to a collective bargaining agreement time to modify their group health plans to meet MCC standards and then re-apply for MCC Certification to the MCC standards in effect at that time.