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Employee Benefits Alert: Connector Issues Final Regulation Establishing "Minimum Creditable Coverage" under the Massachusetts Health Care Reform Act

10/22/2008

Under the individual mandate of the Massachusetts health care reform act (the "Act"),[1] Massachusetts residents age 18 and over must obtain and maintain health insurance, the coverage under which is "minimum creditable coverage." The legislature left it up to the Massachusetts Health Insurance Connector Authority (the "Connector")—an agency established under the Act—to determine what constitutes minimum creditable coverage. On October 17, 2008, the Connector issued a new final rule (the "final rule")[2] intended to further refine and define what constitutes "minimum creditable coverage" for purposes of the Act's individual mandate. This advisory provides an overview of the final rule.

Background

Under the Act's individual mandate, Massachusetts residents are generally required to "obtain and maintain creditable coverage." The Act defines the term "creditable coverage" to mean and include any of the following health plans:

- an individual or group health plan which meets the definition of "minimum creditable coverage" as established by the board of the Connector;
- a health plan including, but not limited to, a health plan issued, renewed, or delivered within or without the commonwealth to an individual who is enrolled in a qualifying student health insurance program (under M.G.L. c. 15A, § 18) or a qualifying student health program of another state;
- Medicare Part A or Part B;
- Medicaid;
- TRICARE;
- a medical care program of the Indian Health Service or of a tribal organization;
- a state health benefits risk pool;
- the federal employee's health plan offered;
- certain public health plans;
- a health benefit plan under the Peace Corps Act;
- coverage for "young adults" under the Act; and
- "any other qualifying coverage required by the Health Insurance Portability and Accountability Act of 1996, as amended, or by regulations promulgated under that act."

The definition of creditable coverage then follows with a list of plans that do not constitute creditable coverage. These include a laundry list of limited-scope and disease-specific plans as well as plans that provide no health coverage or do so only tangentially (*e.g.*, a motor vehicle accident policy that may also cover some medical costs). Workers' compensation, long-term care, and disability policies and plans are similarly excluded.

In 2007, the Connector first adopted rules establishing criteria for "minimum creditable coverage" (the "2007 rules"), under which virtually any "group health plan" coverage was automatically deemed to qualify as minimum creditable coverage before 2009. Beginning January 1, 2009, however, only plans meeting certain requirements will constitute "minimum creditable coverage." These requirements include coverage for certain "core services," preventative and primary care, emergency services, hospitalization, ambulatory services, mental health and substance abuse, limits on co-payments and deductibles, as well as mandated prescription drug coverage. Tracking the requirements of the statute, the 2007 rules also set out a list of items that do not rise to the level of minimum creditable coverage, including, but not limited to:

Accident only, credit only, or limited-scope vision or dental benefits

Hospital indemnity insurance policies if offered as independent, non-coordinated benefits (*e.g.*, policies which provide an in-patient hospitalization benefit not to exceed $500 per day)

Disability income insurance; supplemental liability insurance

Specified disease insurance; insurance arising out of a workers' compensation law or similar law

Automobile medical payment insurance

Earlier this year, in response to questions raised by the regulated community, the Connector board reproposed its minimum creditable coverage regulations (the "2008 proposed rule"). The board also invited comments and held a public hearing. The final rule incorporates many of the suggestions and comments gleaned from the comment process and from the hearing testimony.

Minimum Creditable Coverage under the Final Rule

General Requirements

Beginning January 1, 2009, a "health benefit plan" is deemed to provide minimum creditable coverage if the plan provides "core services" and a "broad range of medical benefits." The term "health benefit plan" is defined to mean and include an individual or group policy of health, accident, and sickness insurance issued by a carrier licensed in Massachusetts or another state, and it also includes self-funded health plans. "Core services" include physician services, inpatient acute care services, day surgery, and diagnostic procedures and tests." For 2009, a "broad range of medical benefits" includes preventive and primary care, emergency services, hospitalization, ambulatory patient services, and prescription drugs.

In 2010, the list of items which constitute a "broad range of medical benefits" is expanded to include diagnostic imaging and screening procedures, including x-rays, emergency services, maternity and newborn care, and radiation therapy and chemotherapy. Plans may impose reasonable exclusions and limitations, including different benefit levels for in-network and out-of-network providers. In the absence of a network, however, the overall health benefit plan design must meet the requirements of the final rule to be deemed to provide minimum creditable coverage.

A health benefit plan may be combined with other health benefit plans for the purpose of complying with the minimum creditable coverage rules. For example, a plan with deductibles and/or out-of-pocket maximums for in-network covered services that exceed prescribed minimum creditable coverage standards may be combined with a health reimbursement arrangement so that the "net" deductible amount (*i.e.*, the annual deductible less the annual Health Reimbursement Account funding) and out-of-pocket maximum of the combined health benefit plans satisfy the applicable minimum creditable coverage standards in the aggregate. Similarly, a health benefit plan that excludes prescription drug coverage may be combined with a separate prescription-drug-only health benefit plan so that the combined plans satisfy the minimum creditable coverage rules.

Co-payments, Deductibles, etc.

Varying levels of co-payments, deductibles, and coinsurance are allowed if disclosed to participants, provided that:

- deductibles for in-network covered services do not exceed $2,000 for an individual and $4,000 for a family; and
- any separate deductible imposed for prescription drug coverage does not exceed $250 for an individual and $500 for a family.

Where a plan includes deductibles or coinsurance for in-network covered services, the plan must set out-of-pocket maximums for in-network covered services that do not exceed $5,000 for an individual and $10,000 for a family. But if the plan's out-of-pocket maximum does not include deductibles, the plan's out-of-pocket maximum for in-network covered services, when combined with the plan's deductible for in-network covered services, cannot exceed $5,000 for an individual and $10,000 for a family. Although in-network out-of-pocket maximums must include certain co-payment amounts, coinsurance, and deductibles, prescription drugs can be excluded.

The final rules include an anti-abuse requirement under which a plan will not be deemed to provide minimum creditable coverage if benefit limitations "are clearly inconsistent with standard employer-sponsored coverage" or where the limitations do not "represent innovative ways to improve quality or manage the utilization or cost of services delivered."

Annual Limits

The final rules do not generally allow for the imposition of an overall annual maximum benefit limitation, nor do they sanction an overall annual maximum benefit limitation based on dollar amount or utilization for any single illness or condition. There are some exceptions. Maximum benefit limitations may be applied to non-core services, subject to the anti-abuse rule described above. Also, benefit limitations are allowed on substance abuse treatment to the extent consistent with federal law, physical therapy, inpatient rehabilitation care services, and durable medical equipment.

Preventative Care

The final rules define "preventative care" to include routine adult physical exams, well baby care, prenatal maternity care, medically necessary child or adult immunizations, and routine GYN exams. Preventive care coverage must generally include three (for an individual) or six (for a family) preventive care visits annually to a physician or other health care provider. Alternatively, the plan may cover preventive care "in accordance with nationally recognized preventive care guidelines." Where a plan imposes a deductible for in-network covered core services, it must nevertheless cover preventive care services on an annual basis *before* imposing a deductible.

HSAs and HDHPs

For 2009, a high deductible health plan (HDHP) within the meaning of Internal Revenue Code § 223 (*i.e.*, an HDHP compatible with a health savings account (HSA)) is deemed to provide minimum creditable coverage. For 2010 and later years, an HSA-compatible HDHP will continue to provide minimum creditable coverage, but only if the carrier or plan sponsor "facilitates access to an HSA administrator (i.e., financial institution) to enable a policy holder to establish and fund an HSA in combination with a federally compliant HDHP."

Note

This is a major reversal of the Connector's position in the 2008 proposed rule, and it should also be welcome by proponents of HSAs. While not giving plan sponsors a "free pass" in future years to offer stand-alone HDHPs, they permit the next best thing. After 2009, an employer need only facilitate HSA access. Presumably, this means that the employer must arrange for an HSA vendor and offer to make HSA contributions via payroll deduction.

Actuarial Equivalence

A health benefit plan that does not meet every element of minimum creditable coverage required by the final regulation but provides for "core services" and covers a "broad range of medical benefits" will nevertheless be deemed to provide minimum creditable coverage if the Connector so determines, provided that the plan

- has an actuarial value equal to or greater than any Bronze-level plan offered through the Connector as certified by an actuary and
- satisfies the final rule's general anti-abuse requirement.

Note

This too is a major change from the 2008 proposed rule, and it appears to be a response, at least in part, to comments submitted by Buck Consultants and the American Benefits Council, among others. There is ample precedent for this approach in the Medical Part D rules, which establish a standard Part D prescription drug benefit but allow for other benefits that are actuarially equivalent. This change should be especially welcome to large multi-state employers with self-funded plans that, while generous, do not match up with the final rule's general minimum creditable coverage requirements. We expect the Connector to issue further guidance establishing an approval process and perhaps setting out some safe-harbor plan designs or options.

Special Rule for Multi-employer Health Plans

The final rule defines the term "multi-employer health benefit plan" as:

> A health benefit plan to which more than one employer is required to contribute, which is maintained pursuant to one or more collective bargaining agreements between one or more employee organizations and more than one employer, and there is evidence that such employer contributions to the Multi-employer Health Benefit Plan were the subject of good faith bargaining between such employee representatives and such employers.

These plans are also commonly known and referred to as "Taft-Hartley" plans. The Connector, in its discretion, may deem a multi-employer health benefit plan maintained pursuant to a collective bargaining agreement in effect on January 1, 2009 to meet minimum creditable coverage for a period not to exceed one year following the expiration date of the collectively bargained agreement that is in effect on January 1, 2009 or, if part of a multi-employer health benefit plan, one year following the date of the last renewing collectively bargained agreement that is part of the multi-employer health benefit plan.

Excluded Coverages

As was the case with the earlier rule, the final rule provides a list of coverage types that do not constitute creditable coverage. These include:

- supplemental health insurance and other policies such as accident only, credit only, or limited-scope vision or dental benefits (if offered separately);
- hospital indemnity insurance policies (where offered as independent, non-coordinated benefits);
- specified disease insurance;
- workers' compensation insurance;
- automobile medical payment insurance;
- insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in a liability insurance policy or equivalent self-insurance;
- long-term care if offered separately; and
- Medicare Prescription drug plans.

Conclusion

The final regulation achieves what appears to be a carefully constructed balance between the text of the statute and the will of the legislature, on one hand, and the legitimate needs and concerns of the regulated community, on the other. The Connector's board and staff are to be commended in this regard. Regrettably, these rules have been announced later in the year than many would have liked, so plan sponsors will need to scramble a bit.

Endnotes

[1] An Act Providing Access to Affordable, Quality, Accountable Health Care, 2006 Mass. Acts c. 58, 2006 Mass. Adv. Legis. Serv. 58 (LexisNexis), *amended by* An Act Relative to Health Care Access, 2006 Mass. Acts c. 324, 2006 Mass. Adv. Legis. Serv. 324 (LexisNexis); An Act Further Regulating Health Care Access, 2006 Mass. Acts c. 450, 2006 Mass. Adv. Legis. Serv. 450 (LexisNexis); *and* An Act Further Regulating Health Care Access, 2007 Mass. Acts c. 205, 2007 Mass. Adv. Legis. Serv. 205 (LexisNexis).

[2] 956 CMR 5.00 (2008).

If you have any questions concerning the information discussed in this advisory or any other employee benefits topic, please contact one of the attorneys listed below or your primary contact with the firm who can direct you to the right person. We would be delighted to work with you.

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