Massachusetts Finalizes Minimum Creditable Coverage Standards

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By:
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On October 17, 2008, the Massachusetts Health Insurance Connector ("Connector") finalized regulations that establish "minimum creditable coverage" standards for health plans.[1] Employers with employees in Massachusetts must act quickly to compare current health plan structures to the final standards to ensure that they are providing "creditable coverage" to participating employees. Participating employees without creditable coverage will not comply with the Massachusetts individual health insurance mandate.

The Individual Mandate

Originally effective July 1, 2007, the individual health insurance mandate requires that all residents of Massachusetts age 18 or older have "minimum creditable" health coverage, if an affordable plan based on their income is available. For 2008 and beyond, an individual is fined for each month that he or she is without creditable coverage. The amount of the fine is up to 50 percent of the least costly available insurance premium.

Creditable Coverage

From July 1, 2007 through December 31, 2008, any health plan coverage is deemed to provide creditable coverage. As of January 1, 2009, a health plan provides "creditable coverage" only if it meets certain requirements, as outlined in the final regulations. Among these requirements are the provision of "core services" and a "broad range of medical benefits." Other requirements include limits on the amounts set for co-payments, deductibles, and maximum benefits.

Core Services

The core services requirement is a new requirement under the final rules. This requirement will be met if the plan provides for all of the following: (1) physician services; (2) inpatient acute care services; (3) day surgery; and (4) diagnostic procedures and tests.

Broad Range of Medical Benefits

As of January 1, 2009, a plan must cover a "broad range of medical benefits." These include, at a minimum, coverage for:

- preventive and primary care;
- emergency services;
- hospitalization;
- ambulatory patient services;
- prescription drugs; and
- mental health and substance abuse services.

Effective January 1, 2010, the broad range of medical benefits that must be provided under a plan will include the items listed for 2009, plus:

- diagnostic imaging and screening procedures;
- maternity and newborn care;
- medical/surgical care; and
- radiation therapy and treatment.

Co-payments, Deductibles, and Co-insurance

Health plans are permitted to include varied levels of co-payments, deductibles, and co-insurance, provided the following are met:

- deductible, co-payment, and co-insurance amounts for in-network and out-of-network covered services are disclosed to participants;
- any deductible for in-network covered services does not exceed $2,000 for an individual and $4,000 for a family per year; and
- any separate deductible applicable to prescription drug coverage does not exceed $250 for an individual and $500 for a family per year.

Out-of-Pocket Maximums

A plan that includes deductibles or co-insurance for in-network, covered, core services must include an out-of-pocket maximum for such services that does not exceed $5,000 for an individual, and $10,000 for a family, per year. If an out-of-pocket maximum is defined without including the deductible, then the out-of-pocket maximum for in-network covered services, when combined with the deductible for such services, cannot exceed the $5,000/$10,000 limit.

Co-payments of over $100, co-insurance payments, and deductible payments made by an individual or family for in-network covered services must be included in calculating any out-of-pocket maximum. Amounts paid for prescription drugs and smaller co-payment amounts, however, are exempt from determining the amount of this maximum.

Exclusions and Limitations

A health plan may impose "reasonable" exclusions and limitations, including different benefit levels for in-network and out-of-network providers, subject to certain restrictions. An overall annual limit that applies to all covered services collectively is not permitted. Similarly, an overall annual limit based on dollar amount or utilization that effectively caps covered core services (individually or collectively) for a year, or for any single illness or condition, is also prohibited.

A health plan may apply maximum benefit limits to non-core services. Effective for the period beginning January 1, 2010, however, the Connector has discretion to determine that a health plan does not provide creditable coverage if the maximum benefit limits: (1) are clearly inconsistent with standard employer-sponsored coverage; and (2) do not represent innovative ways to improve quality, or manage utilization and/or cost of services. Given the broad nature of this provision, further guidance on its application is anticipated.

Preventive Care Services

The final rule includes a revised definition of preventive care services. Under the revised definition, preventive care services include, but are not limited to, routine adult physical exams, well baby care, prenatal maternity care, medically necessary child or adult immunizations, and routine gynecological exams.

A plan that includes a deductible for in-network, covered, core services must cover preventive care services on an annual basis before imposing a deductible. Preventive care visits that are covered prior to any deductible may be subject to co-payments or co-insurance. However, such co-payments or co-insurance amounts must be no greater than the co-payment or co-insurance amounts applicable to primary care or routine doctor visits. Under both the proposed and final regulations, a plan is deemed to satisfy the pre-deductible requirements if it covers three annual preventive care visits for an individual, and six such visits for a family. Under the final regulations, a plan may also meet this requirement if it covers preventive care in accordance with nationally recognized preventive care guidelines that are comparable to the Massachusetts Health Quality Partners' Preventive Care guidelines.

Plan Combinations

A health plan that does not meet creditable coverage standards on its own may be combined with additional health plans so that the combined plans provide creditable coverage. A health plan with deductibles and/or out-of-pocket maximums for in-network services that exceed the limitations of the final rule may be combined with a health reimbursement arrangement so that the net deductible amount and out-of-pocket maximum of the combined plans meet creditable coverage standards.

High Deductible Health Plans

As of January 1, 2009, a high deductible health plan (HDHP) that complies with applicable federal statutory and regulatory requirements automatically satisfies creditable coverage requirements. Effective January 1, 2010, an HDHP provides creditable coverage only if:

- it complies with federal statutory and regulatory requirements;

- it complies with certain aspects of the creditable coverage requirements; and
- a health plan sponsor or carrier facilitates access to a Health Savings Account (HSA) trustee or custodian to enable an individual to establish an HSA.[2]

Actuarial Equivalence Safe Harbor

A health plan that does not meet all creditable coverage requirements may still be creditable if the Connector determines, in its discretion, that the plan: (1) covers core services and a broad range of medical services; (2) contains benefit limitations that are consistent with creditable coverage requirements; and (3) has an actuarial value equal to or greater than any "Bronze-level" plan offered through the Connector based upon an actuarial certification. It is expected that additional guidance on this safe harbor will be issued, as the procedure for submitting a determination request to the Connector has not been specified.

Collectively Bargained Plan Rule

The Connector may also determine, in its discretion, that a health plan maintained pursuant to a collective bargaining agreement in effect on January 1, 2009, complies with creditable coverage requirements for up to one year following the expiration of the applicable collective bargaining agreement. A plan that is part of a multi-employer health plan may be deemed compliant for up to one year following the expiration of the last renewing applicable collective bargaining agreement.

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[1] 956 CMR 5.00

[2] Note that an individual is not required to actually establish an HSA. Only facilitation of access is required.

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