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Employee Benefits Advisory: Massachusetts Health Connector Issues Administrative Bulletin Detailing Actuarial Equivalence for Minimum Creditable Coverage Purposes

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The individual coverage mandate under the Massachusetts health care reform act—Chapter 58 of the Acts of 2006 (the "Act")[1]—generally obligates Massachusetts residents age 18 and older to obtain and maintain affordable health insurance coverage or be subject to a tax penalty. To satisfy this requirement, coverage must constitute "minimum creditable coverage" (MCC). The recent final MCC regulations issued by the Massachusetts Health Insurance Connector Authority (the "Connector") established rules dictating what health insurance coverage will—and will not—satisfy the individual coverage mandate. These regulations are the topic of our October 22, 2008 advisory.

The final MCC regulations are highly prescriptive. It is therefore possible, and even likely, that a plan can be very generous but nevertheless fail to qualify as MCC. This might occur, for example, with a self-funded plan of a large multi-state employer. Recognizing that the strict application of the MCC rules could lead to a less than desirable result, the MCC final regulations include an important exception under which plans are permitted to establish compliance based on actuarial equivalency with the Connector's Bronze-level insurance plan. In the recently issued Administrative Bulletin 01-08, the Connector set out procedures for demonstrating actuarial equivalency, and also provided clarification on mental health and substance abuse benefits and Health Savings Accounts (HSAs) coupled with High Deductible Health Plans (HDHPs). This advisory explains the key features of Administrative Bulletin 01-08. Please see *An Employer's Guide to the 2006 Massachusetts Health Care Reform Act* for a comprehensive explanation of the impact of the Act on employers with employees at Massachusetts locations.

Background

According to the final MCC regulation, 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
- the plan satisfies the final rule's general anti-abuse requirement.

Administrative Bulletin 01-08 provides guidance on how to establish actuarial equivalency.

Basic Rules

Employers have the burden of determining whether their plans meet the MCC standards. A health benefit plan that deviates from the particulars of the MCC final regulation, but meets these criteria, may apply to the Connector for "MCC Certification." This process 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 final MCC regulation. Under the MCC Certification process, a plan sponsor or insurance carrier seeking to have a plan deemed MCC compliant must complete an "MCC Certification Application." 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 in support of the application. The Connector 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."

In connection with the submission process, plans are not required to provide actuarial attestations, but the Connector reserves the right to request an attestation before ruling on an application. Where, for example, a plan is clearly richer than the Commonwealth's Bronze-level coverage option (*i.e.*, "CommChoice Bronze"), the application, along with a detailed benefits summary, should suffice. Where it's a close call, the application should include an actuarial attestation. Also, the mere submission of an actuarial attestation does not ensure that the Connector will certify as to MCC status. The Connector can, and can be expected to, look behind the attestation in order to satisfy itself that the applicable standards have been in fact complied with.

A health benefit plan will *not* be granted an MCC Certification if:

- 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.

While not expressly designated as such, these requirements function as a regulatory anti-abuse rule.

Administrative Bulletin 01-08 includes examples of deviations for which a plan may seek MCC Certification, including the following:

- coverage of preventive care services that deviates from the pre deductible or nationally recognized standard requirements stipulated in the final MCC regulations;
- deductible amount(s) that exceed the limits set forth by the final MCC regulation or that are applied in a different manner than contemplated in the regulation; and
- out-of-pocket maximum amount that exceeds the limits set forth by the final MCC regulation or that is applied in a different manner than contemplated in the final MCC regulation.

Actuarial Equivalence

According to Administrative Bulletin 01-08, actuarial value "is calculated based on the expected medical claims cost to the health plan to provide that health plan's benefits to a standard population," and would "take into account member cost-sharing." It must also take into account "any expected reduction in utilization caused by the presence of cost sharing that might cause a member not to pursue care for certain conditions." For this purpose, two plans are considered to be actuarially equivalent if they have the same or closely similar actuarial value. A plan is deemed to be actuarially equivalent to a Bronze-level plan if the applicant's plan has an actuarial value of at least 100% of any Connector Bronze-level plan. (A summary of benefits and cost-sharing for Bronze- and Gold-level plans can be found at www.mahealthconnector.org.)

Multiple plans may be combined in order to meet MCC. For example, 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 health benefit plans provide MCC.

Effective Date of MCC Certification

Once established, a health benefit plan's MCC Certification is valid until there is a material change to the benefits provided by the plan and/or the Connector Board alters the MCC standards. For this purpose, 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, benefits and/or cost sharing that do not impact MCC standards would not require a plan sponsor or carrier to request MCC recertification.

Because the MCC requirements become more stringent in 2010, it is possible that a certification might be valid for 2009 only. In this instance, recertification would be required for 2010. The Connector also has the right to withdraw a plan's MCC Certification if it subsequently determines that any of the underlying facts, information, or circumstances are "materially inconsistent with the representations and documents submitted in support" of the application.

Mental Health and Substance Abuse Services

Mental health and substance abuse services are not considered "core" services for MCC purposes, but they are considered part of the "broad range of medical services" required to be covered. Administrative Bulletin 01-08 clarifies that a plan may place limitations on these sorts of benefits in a manner that is consistent with the final MCC rule. This requires that limitations on mental health and substance abuse services be consistent with applicable state and federal mental health parity requirements.

High Deductible Health Plans

According to the final MCC regulation, an HDHP will meet MCC in calendar year 2009 if it complies with federal statutory and regulatory requirements for HDHPs (*i.e.*, Internal Revenue Code Section 223). Commencing in 2010, however, to meet MCC, an HDHP also must:

- cover core services;
- cover a broad range of medical benefits; and
- "facilitate access to an HSA."

According to Administrative Bulletin 01-08, the phrase "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 or she so chooses. Importantly, nothing requires an individual to establish or fund an HSA.

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); An Act Further Regulating Health Care Access, 2007 Mass. Acts c. 205, 2007 Mass. Adv. Legis. Serv. 205 (LexisNexis); *and* An Act Making Appropriations for the Fiscal Year 2008 to Provide for Supplementing Certain Existing Appropriations and for Certain Other Activities and Projects, 2008 Mass. Acts c. 302.

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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