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Massachusetts Provides Revised Guidance on Minimum Creditable Coverage Requirements

Starting January 1, 2009, Massachusetts residents who do not have health coverage that satisfies certain minimum creditable coverage requirements will be subject to tax penalties. The Massachusetts Connector recently issued important new guidance on these minimum creditable coverage requirements. If an employer's plan does not satisfy these requirements, employees and their family members age 18 and older enrolled in the plan will be subject to the tax penalties.

Background

The Massachusetts health care reform law took effect July 1, 2007. The law mandates that each Massachusetts resident age 18 and older have health coverage that satisfies minimum creditable coverage (MCC) requirements – an individual who does not have such coverage may be subject to a tax penalty ($912 maximum penalty in 2008). The MCC requirements are "designed to provide individuals purchasing the coverage with financial access to a broad range of health care services, including preventive health care, without incurring severe financial losses as a result of serious illness or injury." Last year, Massachusetts issued draft guidance on the MCC requirements, which, among other things, deferred the effective date of the MCC requirements to January 1, 2009 to allow individuals and employers time to comply. (See our March 21, 2007 *For Your Information*.)

Massachusetts has now issued revised MCC regulations that provide much needed clarification in several key areas and confirm that the MCC requirements will be effective January 1, 2009. Many employer plans may have difficulty satisfying these requirements.

While there is no mandate that an employer's plan satisfy the MCC requirements, employees enrolled in a plan that fails to meet them may be subject to the tax penalty. Therefore, many employers will want to satisfy the MCC requirements.

Revised Regulations on MCC Requirements

The latest regulations provide the following enhanced guidance regarding the MCC requirements.

Broad Range of Medical Benefits. At a minimum, a "broad range of medical benefits" must include coverage for –

- ambulatory surgery, including anesthesia
- diagnostic imaging and screening, including x-rays

- diagnostic laboratory services
- emergency services
- hospitalization, including at a minimum inpatient acute care services
- maternity and newborn care
- medical and surgical care, including preventive and primary care
- mental health services
- prescription drugs
- radiation therapy and chemotherapy.

A health plan can impose reasonable exclusions and limitations, including benefit differentials for in-network and out-of-network benefits.

BUCK COMMENT. *Most employer plans, with the possible exception of "mini-med" or "limited benefit plans," should have no difficulty satisfying this "broad range" requirement.*

Employee Cost Sharing. A health plan can impose copayments, deductibles and coinsurance as long as the following requirements are satisfied –

- Any deductible for in-network services cannot exceed $2,000 for an individual and $4,000 for a family (with an important exception in 2009 for high-deductible health care plans that are coupled with a health savings account (HSA) as discussed below).
- Any separate deductible for prescription drugs cannot exceed $250 for an individual or $500 for a family. (A deductible in excess of $250/$500 that applies to combined medical and prescription drug services satisfies the MCC requirements.)
- A plan that has deductibles or coinsurance must include an out-of-pocket maximum for in-network services that does not exceed $5,000 for an individual and $10,000 for a family. Any copayments over $100 must be counted towards that out-of-pocket maximum. Deductibles, copayments and coinsurance for prescription drugs do not have to be taken into account.
- Plans without networks (e.g., indemnity plans) must satisfy the in-network standards.

BUCK COMMENT. *While the deductible requirements generally should not be a problem, the out-of-pocket maximum limitation will be an issue for some employer plans. For example, plans that do not credit hospital admission or outpatient surgery copayments (often $250 to $500) or mental health coinsurance towards the out-of-pocket maximum, plans that have no family out-of-pocket limit, and plans with an out-of-pocket limit (including deductibles) that exceed the maximums could fail to satisfy the MCC requirements.*

Annual Benefit Limitations. A plan cannot impose an annual maximum benefit limitation that applies to all services collectively. It also cannot impose an overall annual benefit maximum benefit limit based on a dollar amount or utilization (such as office visits or hospital days) that caps covered "core services" for any single illness or condition "except as may be permitted by applicable law." Required core services include physician services, inpatient acute care services, day surgery and diagnostic procedures and tests.

According to examples in the guidance, a plan can impose annual maximum benefit limitations on noncore services such as substance abuse, physical therapy, inpatient rehabilitation services, and durable medical equipment.

While not addressed directly in the guidance, Connector staff has confirmed that services for biologically-based mental health conditions are considered core, while services for non-biological conditions are not. Therefore, under the MCC requirements, annual utilization limits for biologically-based mental health services are not allowed and employee cost sharing for these services, such as deductibles and coinsurance, must be credited towards out-of-pocket maximums.

Connector staff has also confirmed that maximum lifetime limits on benefits are allowed.

> ***BUCK COMMENT.*** *The ability to impose annual benefit limitations on noncore services is an important clarification in the revised regulations because most employer plans include these types of limits. Unfortunately, the guidance does not clearly list those services that are considered noncore or set out any criteria for determining whether services are noncore. In addition, the guidance does not provide any explanation about when core services may be capped under the "except as otherwise permitted by applicable" exception.*
>
> *The treatment of biologically-based mental health as a core service will likely be a problem for many employer plans and will result in those plans not satisfying the MCC requirements.*
>
> *In addition, limited benefit plans – often called mini-med plans – will likely not satisfy the MCC requirements because of their annual benefit limits on core services.*

Preventive Care. A health plan with a deductible for in-network services must cover a minimum number of preventive care visits before imposing the deductible. The proposed revisions would allow plans with a deductible to use either the current standard (i.e., three preventive care visits prior to an individual deductible or six preventive visits for family coverage) or a schedule of frequency that meets nationally recognized standards. Copayments or coinsurance can be applied to preventive care visits as long as they are no greater than the copayments or coinsurance applied to primary care or routine office visits.

> ***BUCK COMMENT.*** *The additional preventive care compliance option is welcome news for employers since few employer plans provide coverage for three/six preventive visits before the deductible. However, plans with in-network deductibles should be reviewed to determine if the preventive care coverage satisfies these requirements.*

Plan Aggregation. The revised regulations allow two or more plans to be combined to satisfy the MCC requirements. For example, where either the deductible or out-of-pocket limits for in-network core services exceed the allowed maximums, the plan can be combined with a health reimbursement arrangement (HRA) so that together the "net" deductible and out-of-pocket maximums satisfy the MCC requirements.

> ***BUCK COMMENT.*** *The addition of a supplemental plan like an HRA may be a viable option for some employers to satisfy the MCC requirements, although it would require the administration of two separate plans*

High-Deductible Health Plans. The original MCC guidance included a special exemption for HSA-compatible high-deductible health plans (HDHPs) that were offered in combination with an HSA – as long as the HDHP/HSA arrangement satisfied federal requirements, the plan was deemed to satisfy the MCC requirements. The revised regulations now provide that starting in 2010, HDHP/HSA arrangements must include the broad range of medical benefits required for MCC. However, the special HSA exemption included in the original regulations will still apply for 2009.

> ***BUCK COMMENT.*** *The HSA revision is a disappointing change. Employers that offer these types of arrangements will need to determine if the combination of the HDHP and the employer HSA contributions satisfy the MCC requirements. Employers who offer a consumer directed plan using a health reimbursement account (HRA) should also review those plans, since the MCC requirements will apply in 2009. These requirements could slow the growth of HDHPs in Massachusetts.*

Timeline for MCC Requirements. A public hearing will be held on the revised regulations on September 9, 2008, and final regulations are anticipated to take effect on October 31, 2008. Since most employers will want to finalize 2009 plan designs well before this date, they will need to rely on these proposed regulations for finalizing plan offerings.

Fair Share Employer Assessment. Employers that do not offer a "fair and reasonable" contribution for health care for their employees are subject to a "Fair Share Employer Assessment" of up to $295 per employee per year. The MCC requirements do not apply in determining whether an employer is subject to this assessment and any health care plan offered by an employer can be used to determine compliance with the fair share requirements.

Disclosing Status as Minimum Creditable Coverage. Although the Massachusetts Division of Insurance requires insurers to disclose in their policies and marketing materials whether or not a policy satisfies the MCC requirements, there is currently no similar requirement for employers that sponsor self-funded plans. However, an employer will want to consider providing this information to employees during open enrollment to help them make their enrollment decisions, especially if one or more of the employer's plans do not meet the MCC requirements.

As discussed in our January 8, 2008 *For Your Information*, no later than January 31st of each year, employers and insurers must furnish individuals who had coverage that met the MCC standards during the previous year with a Form 1099-HC. The Form 1099-HC serves as proof that an individual satisfied the Massachusetts individual

mandate and should not be subject to the tax penalty. This information must also be provided to the Massachusetts Department of Revenue.

Conclusion

Employers should review the health plans they offer to Massachusetts residents to determine whether they satisfy the MCC requirements. Employer plans may have difficulty meeting the mental health and maximum out-of-pocket requirements. Employers with plans that do not comply have several options –

- modify the plan for Massachusetts residents to satisfy the MCC requirements
- offer another plan to Massachusetts residents that satisfies the MCC requirements and give employees a choice of plans
- offer a supplemental plan to Massachusetts residents that when aggregated with the current plan satisfies the MCC requirements
- continue the current plan and inform Massachusetts residents that the plan does not satisfy the MCC requirements.

Multi-state employers may need to decide whether to offer Massachusetts residents different benefits to satisfy the MCC requirements. Buck's consultants would be happy to assist you in deciding the best option for responding to these requirements.