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Massachusetts Finalizes Guidance on Minimum Creditable Coverage Requirements

Starting January 1, 2009, Massachusetts residents age 18 and older who do not have health coverage that satisfies certain minimum creditable coverage requirements may be subject to tax penalties that could exceed $900 per person. Massachusetts recently issued final regulations on these requirements, which may enable employers to establish that their plans satisfy the minimum creditable coverage standards through demonstrating actuarial equivalence. They also provide a delayed effective date for collectively bargained plans and liberalize rules for high deductible health plans offered in conjunction with health savings accounts.

Background

The minimum creditable coverage (MCC) requirements under Massachusetts health law do not apply directly to employers. However, employees and their dependents enrolled in an employer plan that does not satisfy these requirements could be subject to significant tax penalties. Therefore, many employers that cover employees who are Massachusetts' residents will want to offer at least one health plan option that satisfies the MCC requirements.

The Massachusetts Connector Board recently approved final regulations that set out the MCC standards. These regulations modify prior guidance. (See our August 4, 2008 *For Your Information* and August 28, 2008 *For Your Information*.) The most significant modifications in the final MCC requirements are summarized below.

Revised MCC Regulations

Required Benefits

The revised regulations clarify that to meet the MCC requirements a health plan must provide core services and a "broad range of medical benefits." Core services include physician services, inpatient acute care services, day surgery and diagnostic procedures and tests. The new regulations also modify the list of benefits that a plan must provide in order to satisfy the broad range of medical benefits requirement. Under the final regulations, a plan must cover the following in 2009 –

- preventive and primary care
- emergency services
- hospitalization

- ambulatory patient services
- prescription drugs
- mental health and substance abuse services.

Beginning in 2010, a plan must also cover –

- diagnostic imaging and screening, including x-rays
- diagnostic laboratory services
- maternity and newborn care
- medical and surgical care
- radiation therapy and chemotherapy.

BUCK COMMENT. *With the exception of "mini-med" or "limited benefit plans," most employer plans should be able to satisfy this requirement in 2009 and in subsequent years.*

Benefit Limits

The revised regulations retain the prohibition on annual dollar limits or annual visit and day limits on aggregate benefits and on core services. However, they now provide that, beginning in 2010, maximums on even non-core services may cause a plan to fail the MCC requirements if the limits are clearly inconsistent with standard employer-provided coverage and do not represent innovative ways to improve quality or manage costs.

Out-of-Pocket Maximums

The revised regulations provide an exception to the general rule that a plan's calculation of the out-of-pocket maximum must include deductibles paid for in-network covered services (other than for prescription drugs). Under this exception, a plan will not fail to qualify as MCC because the in-network deductible is not included in the out-of-pocket maximum as long as the sum of the out-of-pocket maximum and that deductible does not exceed $5,000 for an individual and $10,000 for a family.

Preventive Care

The revised regulations define preventive care as including, at a minimum, routine adult physical exams, well baby care, prenatal maternity care, medically necessary child or adult immunizations, and routine gynecological exams.

The final guidance retains the requirement that a plan cover annually at least three in-network preventive care visits for an individual and six in-network preventive care visits for a family before imposing an in-network deductible. However, it modifies prior rules to allow plans to meet the pre-deductible preventive care requirement

if benefits are comparable to the Massachusetts Health Quality Partners' (MHQP) Preventive Care recommendations and guidelines. Earlier guidance permitted plans to satisfy the requirement if they provided benefits in accordance with nationally recognized preventive care guidelines.

Actuarial Equivalence

Under earlier MCC regulations, plans were required to satisfy the MCC requirements on a provision-by-provision basis. If a plan failed to satisfy even one provision, it would fail to qualify as minimum creditable coverage.

The final regulations authorize the Connector Board to determine that a plan satisfies the MCC requirements on the basis of actuarial equivalence as long as the plan meets the following requirements –

- The plan covers the required core services and broad range of medical benefits required under the law.
- Any annual maximum benefit limitations satisfy the MCC requirements.
- The plan has an actuarial value equal to or greater than any Bronze-level plan offered through the Connector as certified by an actuary.

BUCK COMMENT. *Many employer plans will not satisfy all of the MCC requirements, even though the overall value of the plan exceeds the value of the minimum MCC requirements. The ability to demonstrate compliance through actuarial equivalence is a significant and welcome change.*

Collectively Bargained Plans

The final regulations include a delayed effective date for collectively bargained plans. Under the final regulations, a plan maintained pursuant to a collective bargaining agreement (CBA) in effect on January 1, 2009 may be deemed, in the Connector's discretion, to meet the MCC requirements for a period not to exceed one year following the expiration date of that CBA. In the case of a multi-employer plan, that period may not exceed one year following the date of the last renewing CBA that is part of that plan.

High Deductible Health Plans with an HSA

The proposed regulations treated high deductible health plans that were HSA-compliant as satisfying the MCC requirements, but only for 2009. Beginning in 2010, these plans would be required to satisfy the MCC requirements, and many would fail.

Under the final regulations, starting in 2010, an HDHP/HSA combination will be deemed to provide minimum creditable coverage as long as the following requirements are satisfied –

- The plan complies with federal HSA requirements.
- The carrier or plan sponsor facilitates access to an HSA administrator.

- The plan provides a broad range of medical benefits, satisfies the maximum benefit limitations to the extent not inconsistent with federal requirements, and satisfies the rules for preventive care.

BUCK COMMENT. *Allowing HSA-compatible high deductible health plans to be deemed creditable in 2010 and beyond is welcome news to employers. It should be noted that the employer is not required to fund the HSA.*

Conclusion

Employers should review their health plan offerings in Massachusetts to determine whether or not their plans satisfy these new requirements. During open enrollment, affected employees will likely be requesting information on the status of the plans they are offered.

Buck's consultants would be happy to assist you in this review and in providing the actuarial equivalence testing and communication support if needed.