

Revisions to MCC criteria:

- Allow lifetime maximums otherwise, 360,000 residents that currently have coverage would be affected by a prohibition on lifetime maximum;
- Federally qualified HSAs will meet the MCC requirements;
- Self insured plans will not have to cover state mandated benefits; and
- Prescription drug coverage shall be included but prior to January 1, 2009, Commonwealth Choice will offer plans with and without drug coverage. The Connector will consult with actuaries, health plans and pharmacy benefits managers to develop alternative minimum prescription benefits which will be brought up for review at the board's June meeting. Any approved alternative will be issued by way of an information bulletin, simultaneous with final regulations.

MCC Regulations criteria are as follows:

1. Comprehensive health benefits plan that includes preventive and primary care, emergency services, hospitalization benefits, ambulatory patient services, **prescription drugs**, and mental health services;
2. No annual or per sickness benefits maximum;
3. No fee schedule of indemnity benefits for medical services (e.g. plan maximum benefit of \$500 per day for inpatient care, or \$50 per office visit, etc.)
4. Medical deductible shall not exceed \$2,000 for individual coverage and \$4,000 for family coverage
5. All products that have an upfront deductible are required to cover preventive care visits prior to the deductible – at least three per individual and six per family. These preventive care visits may be subject to cost-sharing (i.e. co-payments or co-insurance) at no greater rate than applies to office visits.
6. If there is a separate deductible for drug coverage, the deductible may not exceed \$250 for individual coverage and \$500 for family coverage.
7. For health benefit plans that include a deductible and./co-insurance, the maximum out-of-pocket spending for in-network services shall not exceed \$5,000 for individual coverage and \$10,000 for family coverage.
8. The out of pocket maximum must include any upfront deductible, all coinsurance and all services that require \$100 or more in co-payments (e.g. inpatient admission, ambulatory surgery). Prescription drug cost sharing need not count toward the out-of-pocket maximum
9. High deductible plans (HDHP) that are **HSA-compliant shall be exempt from the above requirements and deemed to meet the Connector Authority's minimum creditable coverage standards.**