

MEMORANDUM

To: Board of the Commonwealth Health Insurance Connector Authority

From: Jon Kingsdale, Executive Director

Re: Draft Revisions to Minimum Creditable Coverage (MCC) Regulations

Date: July 3, 2008

While we initially planned to issue an administrative bulletin to provide guidance and clarification with regard to the Connector Authority's "Minimum Creditable Coverage" (MCC) regulations (956 CMR 5.00), we now believe that the more appropriate route to take is a formal one, and rather than an administrative bulletin we are proposing revisions to the regulations. This will allow for public comment and provide interested parties with time to review and comment on the proposed revised regulations.

The revisions -- which are included in the attached redlined version of the regulations -- are intended to address several issues that have been brought to light over the past several months, as well as to provide additional guidance to individuals, employers, carriers, brokers/consultants, and other interested parties with regard to the standards used to determine whether a health benefit plan(s) satisfies MCC requirements.

There are ten areas that staff proposes be revised, each of which is summarized below. Pending your review and approval, we will formally issue these draft regulations, solicit public comment, hold a public hearing, assemble all comments and revise the draft regulations, as appropriate, and bring to the Board for final approval the revised regulations. A proposed timeline can be found at the end of this memo.

1. Section 5.02 -- definitions

Expands the definition of "Health Benefit Plan" to include plans that are licensed or otherwise statutorily authorized to transact business in any state other than Massachusetts.¹

2. Section 5.02 -- definitions
Section 5.03 (2) (h) -- preventive care provided prior to deductible

Revises the regulations with regard to the minimum number of preventive care visits that must be provided prior to a deductible, in recognition of the fact that some health benefit plans base their coverage policies on nationally recognized

¹ This clarification was addressed in administrative bulletin 04-07, issued by the Connector Authority on November 15, 2007.

guidelines for preventive care and not a specific number of visits for all members (e.g., the recommended frequency of preventive care for a child under the age of 1 is materially different than the recommended frequency of preventive care for an adult male of average health risk between the ages of 19 and 40). The proposed revisions would allow health benefit plans with a deductible to use either the 3/6 preventive care visit standard included in the current regulations or a schedule of frequency that meets nationally recognized standards.

3. Section 5.03 (1) -- coverage effective dates

Clarifies that any health benefit plan will satisfy MCC requirements through December 31, 2008, and that the new MCC standards take effect January 1, 2009.

4. Section 5.03 (2) (a) -- broad range of medical benefits

Provides guidance and new requirements with regard to the types of services that, at a minimum, constitute a “broad range of medical benefits.” We have had numerous inquiries as to the term, “broad range of medical benefits,” and believe these services represent a core group that all health plans should cover.

5. Section 5.03 (2) -- aggregate of multiple health benefit plans

Clarifies that an individual may be covered by more than one health benefit plan that, as a stand-alone benefits package, may not meet MCC, but when combined with other benefits plans would satisfy the MCC requirements.

6. Section 5.03 (2) (j) (2)

Section 5.03 (3) (c) -- high deductible health plans (HDHP) and health savings accounts (HSA)

New requirement that the plan of benefits provided for in HDHP/HSA-qualified plans include the broad range of medical benefits, pursuant to the MCC regulations. Given the timing of this proposed revision, staff recommends that this provision not take effect until January 1, 2010.

7. Section 5.03 (2) (b) -- plans that do not utilize a network of providers

Clarifies that a health benefit plan that does not utilize a network (e.g., indemnity plan) must meet the “in-network” standards noted in the MCC regulations (e.g., maximum deductible, out-of-pocket maximum, etc.)

8. Section 5.03 (2) (f) -- annual maximum benefit limits

Clarifies that while overall annual and per illness limits are not permitted, limits on services that are not considered “core services” are allowed, as is typical in most health benefit plans.

- 9. Section 5.02 – definitions
Section 5.03 (2) (g) -- indemnity plans

Clarifies that indemnity plans are permitted but that fee schedules must be based on reasonable and customary charges or other contractual arrangements between providers and the health plan.

- 10. Section 5.03 (3) -- other health benefit plans that meet MCC

Exempts from the Connector Board’s MCC requirements the health coverage provided by the US Veterans Administration² and the health plans offered to members of the AmeriCorps National Service Network and National Civilian Community Corps.

Tentative Timeline

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² This clarification was addressed in administrative bulletin 04-07, issued by the Connector Authority on November 15, 2007.

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