



FINAL REGULATION ADOPTED FOR THE MASS HEALTH CARE REFORM MINIMUM CREDITABLE COVERAGE (MCC) REQUIREMENT

On Friday, October 17, 2008, the Health Connector board adopted a new final Minimum Creditable Coverage (MCC) regulation -- 956 CMR 5.00, which is summarized below. This new MCC regulation replaces the original MCC regulation first adopted by the Health Connector board in June 2007.

OVERVIEW

Changes to the original MCC regulation can be categorized as follows; some are effective 1/1/09 while other changes are delayed until 1/1/2010:

- Preventive Care
- Broad Range of Medical Benefits
- HDHP/HSAs
- Actuarial Equivalence safe harbor
- Collectively Bargained Plans
- Technical Corrections

PREVENTIVE CARE

- There is a new definition of what constitutes preventive care, including routine adult physical exams, well baby care, prenatal maternity care, medically necessary child/adult immunizations, and routine GYN exams.
- In addition to the original 3/6 annual preventive care visit standard in the original regulation, which remains, health benefit plans can also meet the pre-deductible preventive care requirement by following nationally recognized preventive care guidelines that are comparable to those guidelines recommended by the Massachusetts Health Quality Partners (MHQP).

BROAD RANGE OF MEDICAL BENEFITS

In order to meet MCC a health benefit plan must provide core services and a broad range of medical benefits. The core services requirement is new. The broad range of medical benefits requirement in the original MCC regulation will commence in 2009 as planned. Beginning in 2010, the broad range list will be expanded to include those additional benefits proposed by the Connector in the July 2007 proposed MCC regulation.

January 1, 2009

- Core services
- Preventive and primary care
- Emergency services
- Hospitalization
- Ambulatory services
- Mental health and substance abuse
- Rx

January 1, 2010

- Those required for 2009, plus:
- Diagnostic imaging and screening
- Maternity and newborn care
- Medical/surgical care
- Radiation therapy and chemotherapy

PBM Comment: The addition of core services to the January 1, 2009 list appears to be a new requirement, although there is some overlap among core services and the rest of the 2009 list.



NEW BROAD RANGE PART II (No Subterfuge) – Beginning 1/1/2010

Health benefit plans may apply reasonable benefit limitations to the broad range of benefits offered and the MCC regulation contains a separate paragraph on acceptable maximum benefit limitations. The new final MCC regulation, as part of the maximum benefit limitation provisions, adopts a form of “no subterfuge” provision beginning January 1, 2010. While the provision does not use the term “subterfuge,” it makes it clear that the Connector has the discretion to deem a health benefit plan as non-MCC compliant if:

- The maximum benefit limitations established by the health benefit plan are clearly inconsistent with standard employer-sponsored coverage; and
- The maximum benefit limitations established by the health benefit plan do not represent innovative ways to improve quality or manage utilization or cost of services delivered.

PBM Comment: The Connector staff indicated that these new standards were inserted to deal with new health benefit plan designs that may be developed by the market in the future. This provision is one of the required elements for the actuarial equivalence safe harbor. Lastly, this provision may be a candidate for further Connector guidance given its placement in the regulation (section 5.03(2)(f)(3)), which permits maximum benefit limitations for non-core services. Connector statements suggest that it intends these new standards to have broader application than limitations on non-core services.

HDHPs/HSAs

The final regulation does not adopt many of the proposed changes from July 2007, but does add some additional requirements for 2010.

For 2009 only

The HDHP rule contained in the original MCC regulation remains the same for 2009. Basically, an HDHP that complies with federal statutory and regulatory requirements for HDHPs under 26 U.S.C. 223 (i.e., is HSA compatible) is considered MCC compliant.

Beginning January 1, 2010

A HDHP is MCC compliant if:

- It complies with federal statutory and regulatory requirements for HDHPs under 26 U.S.C. 223 (i.e., is HSA compatible – the 2009 standard above); PLUS
- It complies with certain specified MCC requirements (to the extent not inconsistent with 26 U.S.C. 223); and
- The carrier or health plan sponsor facilitates access to an HSA trustee or custodian to enable an individual to establish and fund an HSA in combination with the federally compliant HDHP.

PBM Comment: While access to an HSA must be facilitated, the final MCC regulation clarifies that an individual is not required to establish or fund an HSA account.



NEW ACTUARIAL EQUIVALENCE SAFE HARBOR – Effective 1/1/09

For health benefit plans that are “near misses” with respect to MCC compliance, carriers, plan sponsors or health benefit plans may request the Connector to determine (in its discretion) that the health benefit plan is MCC compliant based on actuarial equivalence IF:

- The health benefit plan covers core services and a broad range of medical services;
- Benefit limitations are consistent with specified MCC requirements (including “no subterfuge”); and
- The health benefit plan has an actuarial value equal to or greater than any Bronze-level plan offered through the Connector as certified by an actuary.

PBM Comment: This new safe harbor will be important to many out of state plans, Taft-Hartley funds and self insured plans. This safe harbor will most certainly be the focus of additional Connector guidance in the coming months.

NEW -- COLLECTIVELY BARGAINED PLAN RULE – Effective 1/1/09

- Connector may, at its discretion, deem a health benefit plan maintained pursuant to a collective bargaining agreement that is in effect on January 1, 2009 to be MCC compliant for a period not to exceed one year following the expiration date of the CBA.
- If the health benefit plan is part of a multi-employer health benefit plan (newly defined in the final regulation) the plan may be deemed MCC compliant for a period not to exceed one year following the expiration of the last CBA in effect on January 1, 2009.

TECHNICAL CORRECTIONS – Effective 1/1/09

The final MCC regulation contains 8 miscellaneous technical corrections identified by the Connector:

- Clarifies that a health benefit plan may not include an overall limit on core services, individually or collectively, per condition or per illness.
- Clarifies that separate Rx deductible is an option, but not a requirement, and that Rx may be included under a global deductible.
- Eliminates regulatory language regarding alternative RX designs as approved by the Connector.
- Out-of-pocket maximum intended to include “covered services,” not just “core services.”
- Clarifies that deductible must be added to OOP maximum limit if plan does not include deductibles in OOP calculation.
- Clarifies regulatory language pertaining to indemnity fee schedule.
- Clarifies that HRAs may be used to cover the gap between a health benefit plan’s deductible and the MCC deductible limit.
- Clarifies that multiple health benefit plans may be combined to meet MCC.

SUMMARY OF EFFECTIVE DATES

January 1, 2009

- Preventive care
- Actuarial equivalence
- Collectively bargained plans
- Technical corrections

January 1, 2010

- Expansion of broad range of medical benefits
- Benefits limit standards
- HDHP/HSA requirements



PARKER BROWN & MACAULAY, P.C.

4 FANEUIL HALL MARKETPLACE
BOSTON, MA 02109

Please contact me if you have any questions or comments.

**Richard A. Szczebak
Of Counsel**

PARKER BROWN & MACAULAY, P.C.

4 Faneuil Hall Marketplace

Boston, MA 02109

Phone (617) 350-7701

Phone: 617-399-0441 (direct)

Fax (617) 350-7744

Email: rszczebak@parkerbrown.com

www.parkerbrown.com

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