956 CMR: COMMONWEALTH HEALTH INSURANCE CONNECTOR AUTHORITY

956 CMR 5.00: MINIMUM CREDITABLE COVERAGE

Section

5.01: General Provisions

Scope and Purpose. 956 CMR 5.00 establishes the criteria for the lowest threshold health benefit plan that an individual must purchase in order to satisfy the legal requirement that a Massachusetts Resident have health coverage that constitutes minimum creditable coverage so as to avoid paying a penalty to the Department of Revenue pursuant to M.G.L. c. 111M, §2. Minimum creditable coverage is designed to provide individuals (and dependents) 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.

5.02: Definitions

As used in 956 CMR 5.00, the following words shall have the following meanings, except where the context clearly indicates otherwise:

Ambulatory Patient Services. All outpatient services regardless of the setting.

Annual Maximum Benefit. A maximum amount that a Health Benefit Plan will pay per year for covered services for an individual or family.

Co-insurance. A percentage of the allowed charge, after any applicable Deductible , that a covered person will pay for covered services received under a Health Benefit Plan.

Connector. The Commonwealth Health Insurance Connector Authority.

Connector Board. The Board of the Connector established by M.G.L. c. 176Q, § 2(b).

Co-payment. A fixed dollar amount, after any applicable Deductible, paid by a Covered Person to a physician, hospital, pharmacy, or other health care provider at the time the Covered Person receives covered services.

Core Services. Physician services, inpatient acute care services, day surgery, and diagnostic procedures and tests.

Covered Person. An individual who is covered under a Health Benefit Plan.

Covered Services. The healthcare services, supplies and drugs that are paid for under the Health Benefit Plan.

Deductible. An annual dollar amount that must be paid by a Covered Person for specified health care services that a Covered Person uses before the Health Benefit Plan becomes obligated to pay for covered services. Some Health Benefit Plans may include separate prescription drug Deductibles. The Deductible amount does not include the Premiums that a Covered Person pays or any Co-payments or Co-insurance that may apply after the Deductible.

Essential Health Benefits. The health benefits listed in 42 U.S.C. § 18022(b), and health benefits defined as essential in regulations promulgated pursuant to 42 U.S.C. § 18022(b).

Health Benefit Plan. Any individual, general, blanket or group policy of health, accident and sickness insurance issued by an insurer licensed under MGL c. 175; a group hospital service plan issued by a non-profit hospital service corporation under MGL c. 176A; a group medical service plan issued by a non-profit medical service corporation under MGL c. 176B; a group health maintenance contract issued by a health maintenance organization under MGL c. 176G; coverage for young adults health insurance plan under MGL c. 176J, § 10; any self-funded health plan, including a self-funded health plan which is an ERISA "employee welfare benefit plan" providing medical, surgical or hospital benefits, as that term is defined in 29 U.S.C. § 1002; and any individual, general, blanket or group policy of health, accident and sickness insurance issued in any state within the United States of America other than the Commonwealth of Massachusetts by an insurer that is licensed or otherwise statutorily authorized to transact business in such other state.

Indemnity Schedule of Benefits. A fixed dollar amount per service, set forth in the subscriber's certificate of coverage as the maximum amount that a health plan is required to pay to the beneficiary or to reimburse the provider of that service.

Multi-employer Health Benefit Plan. A Health Benefit Plan to which more than one employer is required to contribute, which is maintained pursuant to one or more collective bargaining agreements between one or more employee organizations and more than one employer, and there is evidence that such employer contributions to the Multi-employer Health Benefit Plan were the subject of good faith bargaining between such employee representatives and such employers.

Out-of-pocket Maximum. The annual dollar limit that a Covered Person will pay for covered services under a Health Benefit Plan, not including Premiums.

Premium. A monthly payment made by, or on behalf of, a Covered Person to purchase and maintain a Health Benefit Plan, regardless of whether the Covered Person uses health care services or not.

Preventive Health Services. The services that are defined in 42 U.S.C. § 300gg-13.

Resident. As defined in M.G.L. c. 111M, § 1.

5.03: Minimum Creditable Coverage.

(1) A Health Benefit Plan, or the aggregate of multiple Health Benefit Plans, must satisfy the requirements of 956 CMR 5.03(1)(a) through (f) to be considered as providing minimum creditable coverage:

(a) A Health Benefit Plan provides Core Services and a broad range of medical benefits, in accordance with at least the minimum standards set by state and federal statutes and regulations governing the particular Health Benefit Plan. "A broad range of medical benefits" shall include, at a minimum, coverage for:

1. Ambulatory Patient Services, including outpatient, day surgery and related anesthesia;
2. Diagnostic imaging and screening procedures, including x-rays;
3. Emergency services;
4. Hospitalization (including at a minimum, inpatient acute care services which are generally provided by an acute care hospital for covered benefits in accordance with the member's subscriber certificate or plan description);
5. Maternity and newborn care, including prenatal care, postnatal care, and delivery and inpatient services for maternity care;
6. Medical/surgical care, including ~~preventive~~ Preventive Health Services and primary care;
7. Mental health and substance abuse services;
8. Prescription drugs;
9. Radiation therapy and chemotherapy.

(b) A Health Benefit Plan's calculation of any Out-of-pocket Maximum must include any expenditure, including Deductibles, Co-insurance, Co-payments, or similar charges, on behalf of an enrollee with respect to Essential Health Benefits.

(c) A Health Benefit Plan:

1. may not impose an overall Annual Maximum Benefit limitation for the plan that applies to all Covered Services collectively;
2. may not impose an overall Annual Maximum Benefit limitation based on dollar amount or utilization that caps covered Core Services, whether individually or collectively, for a year or for any single illness or condition;
3. may not impose an overall Annual Maximum Benefit limitation based on dollar amount on prescription drugs;
4. may apply utilization limits, so long as limits are quantitative or based on other reasonable medical management techniques, rather than based on dollar limits. However, the Connector, in its discretion, may determine

that a Health Benefit Plan does not meet the standards for minimum creditable coverage if:

a. the Annual Maximum Benefit limitations established by the Health Benefit Plan are clearly inconsistent with standard employer-sponsored coverage; and
b. the Annual Maximum Benefit limitations established by the Health Benefit Plan do not represent innovative ways to improve quality or manage the utilization or cost of services delivered.

(d) A Health Benefit Plan may not limit its contractual commitment to the subscriber to an Indemnity Schedule of Benefits for any Core Services. Nothing in this clause is intended to prohibit carriers from agreeing with providers to fee schedules as a basis for reimbursement for their services, from employing reasonable and customary fee schedules as a basis for reimbursing subscribers or providers, or from otherwise devising provider payment methodologies.

(e) A Health Benefit Plan must cover Preventive Health Services on an annual basis without imposing a Deductible, a Co-payment, Co-insurance, or any other form of cost-sharing.

(f) A Health Benefit Plan, or the aggregate of multiple Health Benefit Plans, that provide(s) coverage for dependents must provide coverage for all Core Services and all of the benefits included in the broad range of medical benefits in accordance with 956 CMR 5.03(1)(a) for all Covered Persons under the Health Benefit Plan.

(2) A Health Benefit Plan, or the aggregate of multiple Health Benefit Plans, that otherwise meets the requirements of 956 CMR 5.03(1) may incorporate the following and continue to be considered as providing minimum creditable coverage:

(a) A Health Benefit Plan may impose reasonable exclusions and limitations, including different benefit levels for in-network and out-of-network providers. Exclusions and limitations on benefits should be identified in plain language and non-discriminatory in their design and application. For a Health Benefit Plan that does not have a network design, the overall Health Benefit Plan design must meet the requirements of 956 CMR 5.03(1) to be considered as providing minimum creditable coverage.

(b) A Health Benefit Plan may impose varied levels of Co-payments, Deductibles and Co-insurance, provided that:

1. the plan must disclose to Covered Persons the Deductible, Co-payment and Co-insurance amounts applicable to in-network and out-of-network Covered Services;
2. any Deductible(s) for in-network Covered Services that are provided as part of the plan benefits shall not in combination exceed $2,000 for an individual and $4,000 for a family;
3. the dollar amounts for individuals specified in 5.03(2)(b)2 shall, unless the Connector Board establishes otherwise for a given calendar year, be adjusted each year by an amount equal to the product of that amount and

the premium adjustment percentage for a calendar year as determined by the United States Secretary of Health and Human Services pursuant to 42 U.S.C. § 18022(c)(4). Such amounts are typically published by the Secretary in the annual Notice of Benefit and Payment Parameters regulations. If the amount of any adjustment is not a multiple of $50, such adjustment shall be rounded down to the next lowest multiple of $50. The dollar amounts for a family specified in 956 CMR 5.03(2)(b)2. shall be increased each year to an amount equal to twice the amount in effect for an individual, as adjusted pursuant to this subdivision 956 CMR 5.03(2)(b)3.; and

4. the dollar amount of any separate Deductible imposed for prescription drug coverage shall, unless the Connector Board establishes otherwise for a given calendar year, not exceed an amount equal to 12.5% of the total Deductible limits for individuals and families, respectively, as determined by 956 CMR 5.03(2)(b)3. If the amount of any adjustment is not a multiple of $10, such adjustment shall be rounded down to the nearest multiple of $10.

(c) If a Health Benefit Plan includes deductibles, Co-payments, or Co-insurance for in-network covered Core Services, the plan must set Out-of-pocket Maximums for in-network Covered Services.

1. The Out-of-pocket Maximum for in-network Covered Services, or the sum of the Out-of-pocket Maximums for in-network Covered Services, shall not exceed the dollar amounts in effect under § 223(c)(2)(A)(ii) of the Internal Revenue Code for self-only and family coverage, respectively, for each taxable year.
2. The dollar amounts for individuals specified in 956 CMR 5.03(2)(c)1. shall refer to the dollar amount in effect under § 223(c)(2)(A)(ii) of the Internal Revenue Code during the tax year 2014, adjusted by an amount equal to the product of that amount and the premium adjustment percentage for a calendar year as determined by the United States Secretary of Health and Human Services. If the amount of any increase is not a multiple of $50, such increase shall be rounded to the next lowest multiple of $50. The dollar amounts for a family specified in 956 CMR 5.03(2)(c)1. shall be increased to an amount equal to twice the amount in effect for individuals as described in 956 CMR 5.03(2)(c)2.

(d) A Health Benefit Plan with Deductibles exceeding 956 CMR 5.03(2)(b) and/or Out-of-pocket Maximums for in-network Covered Services exceeding 956 CMR 5.03(2)(c) may be combined with a health reimbursement arrangement, or HRA, so that, together, the "net" Deductible amount (*i.e.*, the annual Deductible less the annual HRA funding) and Out-of-pocket Maximum of the combined Health Benefit Plans satisfy 956 CMR 5.03(2)(b) and (c).

(e) A Health Benefit Plan that does not meet the standards for minimum creditable coverage under 956 CMR 5.03(1) and (2) on its own may be combined with

additional Health Benefit Plans so that, together in the aggregate, the combined health benefit plans (the net result thereof) satisfy 956 CMR 5.03(1)and (2). For purposes of aggregating multiple Health Benefit Plans under 956 CMR 5.03, the following are examples of permissible aggregations:

1. A Health Benefit Plan that excludes prescription drug coverage may be combined with a separate prescription drug-only Health Benefit Plan so that, together in the aggregate, the combined Health Benefit Plans satisfy 956 CMR 5.03(2)(b).
2. A Health Benefit Plan that excludes coverage for mental health services may be combined with a separate mental health services Health Benefit Plan so that, together in the aggregate, the combined Health Benefit Plans satisfy the standards of minimum creditable coverage.

(3) Notwithstanding any other requirement under 956 CMR 5.03, the following shall be deemed to provide minimum creditable coverage:

(a) a Catastrophic Health Plan as defined in 42 U.S.C. § 18022(e);
(b) any health benefit coverage defined as "creditable coverage" in M.G.L. c. 111M, § 1(b) through (*l*);
(c) a high deductible health plan ("HDPH") which:
    1. complies with federal statutory and regulatory requirements under 26 U.S.C. § 223; and
    2. complies with 956 CMR 5.03(1)(a), (c), (d), and (e) (to the extent the requirements of 956 CMR 5.03(1) are not inconsistent with federal statutory and regulatory requirements for an HDHP under 26 U.S.C. § 223); and either
    3. the carrier or plan sponsor facilitates access to an HSA administrator (*i.e.*, financial institution) to enable a Covered Person to establish and fund an HSA in combination with a federally compliant HDHP; or
    4. the plan sponsor establishes and maintains a Health Reimbursement Arrangement ("HRA") in combination with a federally compliant HDHP.
(d) any health arrangement provided by an established religious organization comprised of individuals with sincerely held beliefs provided that the organization:
    1. is not a for-profit organization;
    2. does not make any direct or indirect representation that the organization has sufficient financing to meet members' anticipated financial or medical needs or that it has had a successful history of meeting members' financial or medical needs, provided that this requirement shall not apply to any financial statement that the organization is otherwise required to disclose by law;
    3. does not use compensated sales agents, sales tactics, or deceptive marketing practices to solicit or enroll members, including that it does not use common insurance terms, such as "health plan," "coverage," "copay," "copayment," "deductible," "premium," and "open enrollment," or refer to itself as "licensed" in advertisements, marketing material, brochures, or other materials related to the arrangement;

4. does not use funds paid by members for medical needs to cover administrative costs;
5. provides disclosure that the organization is not an insurance company and does not guarantee that medical bills will be paid by the organization or any other individuals; such disclosure must be made at initial contact with a prospective member, at the time of any material modification to the terms of the sharing arrangement, and in all advertising, brochures, and marketing materials;
6. reports annually to the Connector any information about membership, operations, and finances as the Connector may require; and
7. meets such other criteria that the Connector may deem appropriate to ensure that individuals participating in such arrangements participate only in those operating in a manner consistent with the requirements described in 956 CMR 5.03(3)(d)(1)-(6).

(e) any currently operating U.S. Veterans Administration healthcare program administered by the U.S. Veterans Administration;

(f) any health plan offered or approved by the Corporation for National and Community Service for members of the AmeriCorps National Service Network (*i.e.*, AmeriCorps State, AmeriCorps National, Volunteers in Service to America ("VISTA"), and National Civilian Community Corps ("NCCC")), pursuant to the Domestic Volunteer Service Act (42 U.S.C. § 4950 *et seq*.) or the National and Community Service Act (42 U.S.C. § 12501 *et seq*.); and

(g) a Health Benefit Plan that does not meet every element of minimum creditable coverage required under 956 CMR 5.03(1), but which the Connector, in its discretion, has determined:
1. conforms with the regulatory requirements under 956 CMR 5.00 relating to Core Services (without limitation) and a "broad range of medical benefits";
2. does not fail the standards of minimum creditable coverage established in 956 CMR 5.03(1)(c)3; and
3. has an actuarial value equal to or greater than any Bronze-level plan offered through the Connector as certified by an actuary.

(4) A group health plan that is maintained pursuant to a collective bargaining agreement in effect on January 1, 2009, may be deemed, in the Connector's discretion, to meet minimum creditable coverage for a period not to exceed one year following the expiration date of the collectively bargained agreement that is in effect on January 1, 2009 or, if part of a Multi-employer Health Benefit Plan, one year following the date of the last renewing collectively bargained agreement that is part of the Multi-employer Health Benefit Plan.

(5) The following shall not be considered to be providing minimum creditable coverage: a plan issued as a supplemental health insurance policy including, but not limited to, accident only, credit only, or limited scope vision or dental benefits if offered separately; hospital indemnity insurance policies if offered as independent, non-coordinated benefits which shall mean policies issued under M.G.L. c. 175 which provide a benefit not to

exceed $500 per day, as adjusted on an annual basis by the amount of increase in the average weekly wages in the commonwealth as defined in M.G.L. c. 152, § 1, to be paid to an insured or a dependent, including the spouse of an insured, on the basis of a hospitalization of the insured or a dependent; disability income insurance; coverage issued as a supplement to liability insurance; specified disease insurance that is purchased as a supplement and not as a substitute for a health plan and that meets any requirements the commissioner of insurance, by regulation, may set; insurance arising out of a workers' compensation law or similar law; automobile medical payment insurance; insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in a liability insurance policy or equivalent self insurance; long-term care if offered separately; coverage supplemental to the coverage provided under 10 U.S.C. § 55 if offered as a separate insurance policy; or any policy subject to M.G.L c. 176K or any similar policies issued on a group basis, including Medicare Prescription drug plans.

5.04: Administrative Bulletins

The Connector may periodically issue administrative bulletins containing interpretations of 956 CMR 5.00 and other information to assist compliance under 956 CMR 5.00.

5.05: Severability.

The provisions of 956 CMR 5.00 are hereby declared to be severable. If any section or portion of sections 956 CMR 5.00, or the applicability thereof to any person or circumstances, is held invalid by any court of competent jurisdiction, the remainder of 956 CMR 5.00, or the applicability thereof to other persons or circumstances, will not be affected thereby.

REGULATORY AUTHORITY

956 CMR 5.00: M.G.L. c. 111M, § 1 and M.G.L. c. 176Q, § 3.