956 CMR: COMMONWEALTH HEALTH INSURANCE CONNECTOR AUTHORITY

956 CMR 5.00 MINIMUM CREDITABLE COVERAGE

Section

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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 a co-payment, if any, 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 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.

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.

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 a covered person to purchase and maintain a health benefit plan, regardless of whether the covered person uses health care services or not.

Preventive Care. Covered services provided by a health benefit plan in accordance with nationally recognized preventive care guidelines including, but not limited to, routine adult physical exams, well baby care, prenatal maternity care, medically necessary child or adult immunizations, and routine GYN exams.

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

5.03: Minimum Creditable Coverage.

(1) For the period beginning on July 1, 2007 and ending on December 31, 2008, the following shall be deemed to provide minimum creditable coverage:

(a) any health benefit plan; and
(b) any health benefit coverage defined as "creditable coverage" in M.G.L. c. 111M, § 1(b) through (l).

(2) For the period beginning on January 1, 2009, a health benefit plan, or the aggregate of multiple health benefit plans, shall be considered as providing minimum creditable coverage if the following requirements of 956 CMR 5.03(2)(a) through (i) are satisfied:

(a) A health benefit plan provides 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 (outpatient, day) surgery, including related anesthesia
    2. Diagnostic imaging and screening procedures, including x-rays
    3. Diagnostic laboratory tests
    4. Emergency services
    5. 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)
    6. Maternity and newborn care
    7. Medical/surgical care, including preventive and primary care
    8. Mental health services
    9. Prescription drugs
    10. Radiation therapy and chemotherapy

(b) A health benefit plan may impose reasonable exclusions and limitations, including different benefit levels for in-network and out-of-network providers. 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(2) to be considered as providing minimum creditable coverage.

(c) 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 for in-network covered services shall not exceed $2,000 for an individual and $4,000 for a family; and
    3. any separate deductible imposed for prescription drug coverage shall not exceed $250 for an individual and $500 for a family, unless prescription

drug coverage is provided pursuant to an alternative plan design, in conformity with 956 CMR 5.03(2)(i)(2).

(d) If a health benefit plan includes deductibles or co-insurance for in-network core services, the plan must set out-of-pocket maximums for in-network covered core services that do not exceed $5,000 for an individual and $10,000 for a family.

(e) A health benefit plan's calculation of any out-of-pocket maximum must include all the following payments for in-network covered services made by the individual or family: co-payments over $100, coinsurance and deductibles; provided, however, that amounts paid for prescription drugs, whether through deductibles, co-insurance or co-payments, need not be considered in calculating the out-of pocket maximum.

(f) A health benefit plan may not impose:

1. an overall annual maximum benefit limitation for the plan that applies to all covered services collectively;
2. an overall annual maximum benefit limitation based on dollar amount or utilization that caps covered core services for any single illness or condition, except as otherwise may be permitted by applicable law.
3. annual maximum benefit limitations may be applied to services that are not considered core services, as defined by 956 CMR 5.02. Examples of limitations that are allowed include, but are not limited to, the following:
    a. Annual benefit limits on substance abuse treatment, as substance abuse treatment is not considered a covered core service.
    b. Annual benefit limits on physical therapy, as physical therapy is not considered a covered core service.
    c. Annual benefit limits on inpatient rehabilitation care services, as inpatient rehabilitation care services are not considered a covered core service.
    d. Annual benefit limits on DME, as DME is not considered a covered core service.

(g) For the coverage of core services, a health benefits plan may not limits its contractual commitment to the subscriber to an Indemnity Schedule of Benefits. 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.

(h) A health benefit plan that imposes a deductible for in-network covered services must cover the following on an annual basis before imposing a deductible:

1. Preventive care visits:

a. i. for individual coverage, at least three preventive care visits to a physician or other health care provider; and
   ii. for family coverage, at least six preventive care visits to a physician or other health care provider; or
b. If part of the health benefit plan's formal benefit design, preventive care in accordance with nationally recognized preventive care guidelines.

2. Any preventive care visits covered before the imposition of a deductible may be subject to co-payments or co-insurance, provided, however, that such co-payments or co-insurance shall be at no greater than the co-payment or co-insurance applied by the health benefit plan to primary care or routine physician office visits.

(i) A health benefit plan must cover prescription drugs in one of the following ways:

1. Include prescription drugs as a covered medical benefit, after a deductible of no more than $250 for individual coverage and no more than $500 for family coverage; or
2. If specified in an administrative bulletin issued pursuant to approval of the Connector Board, alternative plan designs that would allow for coverage of preventive prescription drugs without any deductible, in addition to coverage of other prescription drugs with a deductible, co-payment or co-insurance, for a projected average increase of no more than five percent in the price of premiums.

(j) Under 956 CMR 5.03(2), "the aggregate of multiple health benefit plans" may be used to satisfy the requirements of 956 CMR 5.03(2)(a) through (i). A health benefit plan that does not meet the standards for minimum creditable coverage under 956 CMR 5.03(2)(a) through (i) 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(2)(a) through (i). For purposes of aggregating multiple health benefit plans under 956 CMR 5.03, a health savings account ("HSA") shall be considered a health benefit plan.

1. A health benefit plan with deductibles exceeding 956 CMR 5.03(2)(c)2 and/or out-of-pocket maximums for in-network covered core services exceeding 956 CMR 5.03(2)(d) may be combined with a health reimbursement arrangement, or HRA, so that, together in the aggregate, the "net" deductible amount and out-of-pocket maximum of the combined health benefit plans satisfy 956 CMR 5.03(2)(c)2 and (d).
2. A health benefit plan with deductibles exceeding 956 CMR 5.03(2)(c)2 and/or out-of-pocket maximums for in-network covered core services exceeding 956 CMR 5.03(2)(d) may be combined with a health savings account, or HSA, so that, together in the aggregate, the "net" deductible amount and out-of-pocket maximum of the combined health benefit plans satisfy 956 CMR 5.03(2)(c)2 and (d); provided that

a. the health benefit plan is a high deductible health plan ("HDHP") which, along with an HSA, complies with federal statutory and regulatory requirements for HDHPs and HSAs, respectively, under 26 U.S.C. § 223, and
b. the combined HDHP and HSA complies with 956 CMR 5.03(2), to the extent the requirements of 956 CMR 5.03(2) are not inconsistent with federal statutory and regulatory requirements for an HDHP under 26 U.S.C. § 223, and
c. the HDHP, if employment-based, is part of a program designed to enable employees to establish an HSA pursuant to 26 U.S.C. § 223, or
d. the HDHP, if not employment-based, is purchased individually by a person who establishes (or has established) an HSA pursuant to 26 U.S.C. § 223.

3. 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)(c)3.

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

(a) a Young Adult Plan as defined in MGL c. 176J, § 10;
(b) any health benefit coverage defined as "creditable coverage" in M.G.L. c. 111M, § 1(b) through (l);
(c) for calendar year 2009 only, a health benefit plan that does not otherwise comply with 956 CMR 5.03(2)(a) through (i); provided that
    1. the health benefit plan is a high deductible health plan ("HDHP") complying with federal statutory and regulatory requirements for HDHPs under 26 U.S.C. § 223; and
    2. the HDHP, if employment-based, is part of a program designed to enable employees to establish an HSA pursuant to 26 U.S.C. § 223, or
    3. the HDHP, if not employment-based, is purchased individually by a person who establishes (or has established) an HSA pursuant to 26 U.S.C. § 223.

(d) any health arrangement provided by established religious organizations comprised of individuals with sincerely held beliefs;
(e) Commonwealth Care Health Insurance plans as established by M.G.L. c. 118H;
(f) any currently operating U.S. Veterans Administration healthcare program administered by the U.S. Veterans Administration; and
(g) 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*.).

(4) 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 chapter 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 of 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.