

956 CMR: COMMONWEALTH HEALTH INSURANCE CONNECTOR AUTHORITY

956 CMR 5.00 MINIMUM CREDITABLE COVERAGE

Section

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5.01 General Provisions

1. 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.

2. Authority. 956 CMR 5.00 is promulgated in accordance with the provisions of M.G.L. c. 111M, § 1 and M.G.L. c. 176Q, § 3.

3. Effective Date. 956 CMR 5.00 is effective on July 1, 2007

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, section 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 section 10 of MGL c. 176J; and 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. section 1002.

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.

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

5.03: Minimum Creditable Coverage.

1. For the period beginning on July 1, 2007, the following shall be deemed to be providing minimum creditable coverage: (a) any health benefit plan; (b) any health benefit coverage defined as “creditable coverage” in M.G.L. c. 111M, section 1(b)-(l); (c) any high deductible health plan (“HDHP”) that complies with federal statutory and

regulatory requirements for Health Savings Accounts under 26 U.S.C. section 223; (d) any health arrangement provided by established religious organizations comprised of individuals with sincerely held beliefs; and (e) Commonwealth Care Health Insurance plans as established by M.G.L. c. 118H .

2. For the period beginning January 1, 2009 , any health benefit plan shall be providing minimum creditable coverage only if it satisfies all of the following requirements:

- a. Coverage under a health benefit plan, or the aggregate of multiple health benefit plans, must provide, in addition to the other requirements of 956 CMR 5.03, a broad range of medical benefits, including but not limited to, preventive and primary care, emergency services, hospitalization, ambulatory patient services, prescription drugs, and mental health services, in accordance with at least the minimum standards set by state and federal statutes and regulations governing the particular health benefit plan.
- b. A health benefit plan may impose reasonable exclusions and limitations, including different benefit levels for in-network and out-of-network providers.
- 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 an overall annual maximum benefit or a per illness annual maximum benefit for covered core services.

- g. A health benefit plan may not impose a fee schedule of indemnity benefits for in-network covered services that are medical benefits required to be part of a health benefit plan providing minimum creditable coverage.
- h. A health benefit plan that imposes a deductible for in-network benefits must cover the following on an annual basis before imposing a deductible: (1) for an individual, at least three preventive care visits to a physician or other health care provider; and (2) for a family, at least a total of six preventive care visits to a physician or other health care provider. 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. Any 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 ranging from \$0 to \$250 for individual coverage and ranging from \$0 to \$500 for family coverage; or
 - (2) If specified in an administrative bulletin issued pursuant to approval of the Connector's 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.

3. Notwithstanding any other requirement under section 5.03, the following shall be deemed to be providing minimum creditable coverage: (a) a health benefit plan which is a Young Adult Plan as defined in MGL c. 176J section 10; (b) any health benefit coverage defined as "creditable coverage" in M.G.L. c. 111M, section 1(b)-(1); (c) any high deductible health plan ("HDHP") that complies with federal statutory and regulatory requirements for Health Savings Accounts under 26 U.S.C. section 223; (d) any health arrangement provided by established religious organizations comprised of individuals with sincerely held beliefs; and (e) Commonwealth Care Health Insurance plans as established by M.G.L. c. 118H .

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 section 1 of M.G.L. c. 152, 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 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: M.G.L. c. 176Q.