To: Members of the Connector Board

Cc: Jon Kingsdale, Rosemarie Day

From: Jamie Katz

Re: Proposed regulatory changes

Date: June 4, 2007

The board recently finished a series of hearings on three sets of regulations: proposed regulations dealing with minimum creditable coverage (956 CMR 5.00), affordability (956 CMR 6.00) and the affordability schedule, emergency regulations on Section 125 plans (956 CMR 4.00), and amended Commonwealth Care eligibility regulations (956 CMR 3.00). (A summary of the substantive comments was sent out on Friday.)

In the hearings and written comments, we received a large number of thoughtful and valuable suggestions and recommendations. We are very appreciative of the time and attention that so many people put into their testimony. We have reviewed all of the oral and written material and considered the many proposals put before us.

In making the recommendations outlined below, we have kept certain principles in mind.

First, the Board has already made a series of difficult, complicated, and interrelated decisions concerning minimum creditable coverage and affordability. We did not feel it appropriate for the staff to make recommendations that would substantially alter significant policy decisions previously made by the board.

Second, we view our regulations as a work in progress: we need to move forward now with guidance for employers and residents, while learning from experience and actively exploring future refinements.

We do need to put the minimum creditable coverage and affordability regulations in place in a timely manner to ensure that employees, employers, and members of the public know what the rules are on July 1, 2007. Further, the Connector itself needs to know how to implement our various programs.

At the same time, we recognize that we may need to revise regulations and operations as we gain experience with health care reform. Before staff recommends significant changes to the draft regulations, voted unanimously by the Board, we want to gather more information concerning the impact of these regulations and proposed changes thereto.

In that spirit, staff recommends some, but by no means all, of the suggestions made to us in the course of the hearings. (Indeed, we could not accept all of the suggestions, given that some of them contradict each other.) Among the suggestions which we do not recommend at this time, staff will explore for future re-consideration four specific proposed changes to the regulations:

1. To accumulate copayments below $100 toward out-of-pocket maximums;

2. To set a floor on allowable lifetime coverage maximums;

3. To subject HSA-related high deductible health plans to other MCC requirements;

4. To consider whether to grant some relief, through the appeal process or otherwise, in situations where premiums exceed 10% of income.

This memorandum will not address all of the proposals and suggestions set out in the hearings and written comments. Some of those suggestions had already been addressed by the board, either directly or indirectly, while others dealt with issues beyond the control of the Connector, for example, rejecting c. 58 in favor of a single payor system. Rather, this memorandum will address those suggestions which were repeatedly cited in testimonies, and are pertinent to these regulations, whether or not staff recommends their acceptance. The staff makes the following recommendations:

Proposed revisions to minimum creditable coverage (MCC) regulations

Recommended

Certain comments requested that veterans with access to benefits through the Veterans Administration be deemed to have met MCC standards. The VA system, however, provides certain kinds of services, and not insurance, and those services may not be readily accessible in all parts of the state. Further, we do not know how the levels of services may vary for different individuals. Rather than deem Veterans Administration services to meet MCC in all instances, therefore, we recommend that individuals may use as a basis for an appeal of the penalty the fact that they have access to Veterans Administration services.

Comments from Taft-Hartley administrators requested that we make clear that the ban on annual maximums is limited to certain services. We have clarified the regulations to indicate that the ban on annual benfits caps applies only to core services, which we have defined as physician services, in-patient acute care services, day surgery, and diagnostic procedures.

Comments from certain companies and brokers indicated that they sought clarity as to whether their insurance plans, which couple high deductible plans from licensed insurers with self-funding by employers, would meet MCC standards. We have received sufficient information to recommend that these split-funded plans, with combined

benefits meeting or exceeding MCC standards, be deemed to meet MCC and have made a small revision to reflect that change.

We have also made a small change to the waiver provisions that would allow individuals to seek a waiver on the grounds that they have purchased comparable health insurance plans that, while not precisely consistent with MCC, provide comparable or substantially similar coverage. This again results from comments from Taft-Hartley plan administrators.

Not recommended at this time

A number of comments suggested that the MCC requirements are, essentially, too prescriptive and set too high a floor. Most of those commenting argued that individuals and companies should have more flexibility to meet their particular circumstances and the needs of the market. In addition, they argued that the Legislature intended that the MCC was designed to establish a minimal floor and that the Board has, instead, created a substantially higher platform that is costly and interferes with the abilities of companies to control costs and individuals to choose plans appropriate to their situations. As you are aware, the Board extensively debated the appropriate level for MCC and determined that it wanted to set a standard based on certain fundamental principles. Given those extensive discussions, the staff determined that it would not be appropriate to advance this recommendation at this time.

A number of comments requested that the Board drop the requirement of prescription drugs. Again, because this issue had been fully debated by the Board before it defined MCC, we chose not to adopt this recommendation at this time.

A number of comments requested that all medical expenses, including co-pays less than $100, should count toward annual out-of-pocket caps on subscriber spending toward covered services. The Board addressed this issue during its deliberations. None of those making the comments addressed the administrative challenges that this particular request entails for carriers, nor the argument that “modest” copayments on ambulatory services help moderate inappropriate utilization of services. Staff recommends no action on this request at this time.

A number of comments suggested that the specified maximum amount of deductibles ($2,000 individual/$4,000 family) are too high, while others argued that the maximum deductibles are set too low and should be increased. Again, given the extensive debate by the Board on this issue coupled with the interrelationships between the various parts of the MCC requirements, the staff recommends against any changes at this time.

Similarly, commenters suggested that:

the Board should set high caps on lifetime benefits, in the range of $1 million to $2 million;

the Board should increase the number of preventive visits before the deductibles; and

the Board should allow existing high deductible plans attached to HSAs, but should prohibit new ones.

Since the Board had considered and debated all of these issues, some quite extensively and in detail, we determined that it was not appropriate to take any action at this time.

One commenter, addressing our use of the term "preventive care," asked that we use a very extensive and expansive IRS definition of preventive care. We felt that the IRS definition was far broader in scope than anything that the Board has ever contemplated and so have not recommended the use of that definition. Rather, we will gather more information about how plans interpret the phrase "preventive care" and then determine whether we need to promulgate a specific definition.

Blue Cross Blue Shield of Massachusetts, among other issues, asked for a change pertaining to certain of their plans under which BCBS is not required to provide preventive care to adults. BCBS wanted language that would make clear that it could comply with the existing state insurance law, and not the Connector regulation requiring that individuals receive up to three preventive care visits prior to imposition of a deductible. At this point, we have not accepted this proposal and have clarified our regulations to make clear that the state insurance law may have set a floor but the MCC regulations, in certain instances, may raise the requirements for carriers.

Proposed revisions to the affordability regulations or affordability schedule

Recommended:

Change "gross income" to "adjusted gross income" because this will make the measure of disposable income fairer for people who have a variety of significant expenses, available to them as deductions from taxable income, especially the self-employed (including, in particular, artists and reservists who derive the most significant tax benefit).

Change certain definitions to make them consistent with DOR to lessen confusion: For example, the term "dependent" replaces children. A single parent with one child will be treated as family ("head of household"), not a couple, for affordability purposes.

We will make certain other technical changes to accommodate the needs of DOR.

We received a number of comments requesting changes to our waiver standards. In general, comments suggested that our standards should be less restrictive and we also received certain specific suggestions. We make the following recommendations:

> As a more general standard, we recommend adding the following waiver criteria--"If purchase of insurance would deprive the individual such that his or her health or life would be endangered, or the individual would be deprived of food, shelter, clothing, or other necessities such that he or she would be at risk of serious deprivation." This language is taken from a Medicaid regulation dealing with transfer of assets of a nursing home resident.
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> We received comments suggesting that our affordability schedule should address families with more children. Rather than alter the affordability schedule, which would have policy implications and would complicate the preparation of tax returns, we recommend adding a waiver providing that family size (number of children) will be a ground to consider when applying for a waiver of the penalty.

Finally, we have revised the affordability schedule to make clear that the Board, as required by law, has considered deductibles in setting that schedule.

Not recommended at this time

Certain comments requested that the affordability and premium schedules should be put into Connector regulations, rather than to have them established separately, as we have proposed. We have not accepted this request because, first, we do not believe that the law requires that the schedules go into regulations. But more important, as a practical matter, the Board is required to "publish" schedules each year. We do not expect to revise the regulations each year. While the board has said that it will have a public process to review and discuss the schedules, it will be more burdensome for the board to have to reopen and then re-promulgate regulations each year simply to deal with the schedules.

Certain comments requested that we add a waiver ground on the basis that an individual's premiums have reached 10% of gross income. This could be the case above median income, where the sliding scale levels off. As indicated above, we recommend looking at this in the future.

One group asked the Board to add another "step" to the individual affordability schedule by having it run up to $60,000 (beyond the current $50,000), with a premium level set at $400. The Board has already debated the affordability schedule at length. The Board was comfortable with the $50,000 level based on the notion that it represented the median income for an individual in Massachusetts, coupled with the premiums available to individuals. There is no reason to revisit this issue at this point. In addition, any individual suffering financial hardship at this level of income does have the appeals procedures available.

Certain comments requested that families under 150% of FPL should not be liable for the individual mandate. First, this group would include only those who have not taken Commonwealth Care for free, or who had ESI offered to them at 100% subsidy. Removing the threat of a penalty would remove an incentive for these individuals to take "free" insurance. Moreover, they will have access to the broadened waiver provisions. As a result, the staff recommends that the Board not accept this request at this time.

Proposed changes to eligibility regulations (dealing with Commonwealth Care premiums)

We recommend that the Board not accept any of the following recommendations to the Commonwealth Care eligibility regulations. In each case, we do not have sufficient information to determine whether they are financially feasible. Until we have a more stable Commonwealth Care program, with a clearer understanding of the on-going number of enrollees and the costs to the Commonwealth, we do not recommend considering changes that might add substantial costs:

move those patients between 100-150 of FPL from Plan Type II to Plan Type I;

provide dental benefits to Commonwealth Care enrollees in Plan Types II, III, and IV; and

allow employed individuals who have access only to relatively expensive employer-subsidized insurance into Commonwealth Care.

We do recommend one modest change to the Commonwealth Care regulations that make clear that individuals in waiting periods in Taft-Hartley plans are eligible for Commonwealth Care, as are other employees in employer-set waiting periods.

Section 125 Plan regulations

We have retained the same revisions that we identified at the last board meeting:

an exemption for Taft-Hartley employers; and

a modest language change to make clear that employers who cover 100% of the insurance of their employees not exempted by the Section 125 regulations are not required to have Section 125 plans.

We have also changed the time deadlines in the regulations so that there will be more consistency among state agencies as to the period which employers must use to measure the number of individuals that they employ.