

Legislative Update

Employee Benefits



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Massachusetts Minimum Creditable Coverage: What You and Your Employees Need to Know

If you have employees who reside in the Commonwealth of Massachusetts, age 18 and over, they are likely to be impacted by Massachusetts health care reform. And you and your health insurance carriers have some new responsibilities, too.

Effective January 1, 2009, Massachusetts established health care reform requiring specific minimum benefit requirements, or Minimum Creditable Coverage (MCC), to be carried by all Massachusetts adult residents.

These minimum standards are designed as part of Massachusetts' landmark health reform to protect policyholders from financial hardship should they get sick, by requiring them to purchase plans that meet basic health needs.

The body overseeing implementation and regulation of the state's universal health coverage laws is the Massachusetts Commonwealth Health Insurance Connector, "Connector."

Employer, Carrier and Plan Sponsor Responsibilities

Employers, carriers and plan sponsors are NOT required to provide coverage that meets the Connector's MCC standards, however, they do need to determine if their health benefit plans satisfy the MCC standards.

All carriers, employers and plan sponsors are required to provide a written statement annually to each subscriber or covered individual residing in Massachusetts (even if the employer is out of state but employs

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Massachusetts residents) to whom they have provided minimum creditable coverage in the previous calendar year. The written statement is referred to as MA 1099-HC (see sample attached as part of this Legislative Update, although as of this writing, it is not yet final). Members use these written statements to complete their tax return.

In addition to issuing written statements, electronic reports must be submitted to the Massachusetts Department of Revenue. In practice, most employers are arranging for their health insurance carriers to assume the electronic filing responsibility on their behalf.

Massachusetts-licensed health insurance companies must put an MCC compliance notice on their plans to indicate whether they meet MCC requirements (sample notice language is available at the link shown below).

Plans offered through the Connector and MassHealth DO meet the standards, as do plans that are compliant with federal rules regarding high deductible health plans (HDHPs) and health savings accounts (HSAs).

Self-insured plans and fully-insured plans which are not sold in Massachusetts are not required to provide such disclosure.

Sample language for employer notice and

carrier disclosures is available at:

<http://www.mass.gov/legis/laws/mgl/62c-8b.htm>
and

http://www.mass.gov/?pageID=ocaterminal&L=6&L0=Home&L1=Business&L2=Insurance&L3=Division+of+Insurance+Regulatory+Information&L4=DOI+Regulatory+Bulletins&L5=2008+DOI+Bulletins&sid=Eoca&b=terminalcontent&f=doi_bulletins_bulletins_08_02&csid=Eoca

To clarify, MCC requirements are not imposed on employers, nor is there a mandate on employers to offer MCC-level coverage. Rather, the mandate requires individuals to acquire and maintain MCC-compliant health insurance.

As such, neither self-insured nor fully-insured plans MUST comply with the law, but employers are working with their insurance carriers or are amending their insurance plans, to ensure compliance for their employees who are residents of Massachusetts.

What is Minimum Creditable Coverage?

MCC represents the absolute minimum benefits Massachusetts adult residents need to carry in order to be considered insured, and thereby avoid tax penalties. The Commonwealth of Massachusetts anticipates that most plans already meet the MCC standards.

For most plans, the 2009 MCC standards include:

- Coverage for a comprehensive set of services:
 - preventive and primary care
 - emergency services
 - hospitalization
 - ambulatory patient services
 - prescription drugs
 - mental health and substance abuse services
- Doctor visits for preventive care, without a deductible.
- A cap on annual deductibles of \$2,000 for an individual and \$4,000 for a family.
- For plans with up-front deductibles and/or co-insurance on core services (e.g., physician services, inpatient acute care services, day surgery, and diagnostic procedures and tests), an annual maximum on out-of-pocket spending of no more than \$5,000 for an individual and \$10,000 for a family.
- No caps on total benefits for a particular illness or for a single year. MCC regulations do not preclude a plan from having a lifetime maximum, although a plan cannot have an annual benefit maximum (except for Young Adult Plans, which are deemed by the statute to meet MCC and are able to have an annual benefit maximum). However, if, as part of the MCC Certification process, plans are submitted to the Connector by an employer or carrier because they do not meet the exact letter of the MCC regulations, this component may be considered by the Connector in its decision-making as to whether the plan should be granted MCC Certification.
- No policy that covers only a fixed dollar amount per day or stay in the hospital, with the patient responsible for all other charges.
- For policies that have a separate prescription drug deductible, it cannot exceed \$250 for an individual or \$500 for a family.

Higher Standard Beginning in 2010

There are a few new, higher standards in the amended regulations that will take effect on January 1, 2010 (*be aware that 12-month plans with renewal dates between February and December 2009 will be affected by the new requirements for those months that carry over into 2010*).

For example, beginning January 2010, the underlying health benefits in HDHPs will need to include a broad range of medical services and pre-deductible preventive care requirements.

The following will also be included in MCC beginning in 2010:

- diagnostic imaging and screening, including x-rays
- diagnostic laboratory services
- maternity and newborn care
- medical and surgical care
- radiation therapy and chemotherapy.

Self-assessment

The Connector expects that carriers, employers and plan sponsors will self-assess to determine whether their plans meet the MCC standards set forth in the Regulation. If you determine that your plan meets MCC standards, you do not need to seek any form of approval or certification from the Connector. The Commonwealth assumes that most health benefit plans will fall into this self-assessment category.

To determine whether your plan(s) meets MCC requirements, answer the MCC checklist questions found at:

<http://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/Health%2520Care%2520Reform/What%2520Insurance%2520Covers/MCC%2520Background/MCC%2520checklist.pdf>

To get you started, we have also provided a brief checklist at the end of this Update.

MCC Certification by the Connector

The Regulation provides the Connector with the discretion to deem health benefit plans that deviate modestly from the MCC standards as providing minimum creditable coverage if the plans can demonstrate they

meet certain criteria. This process is referred to as MCC Certification and is designed to provide plans a way to comply with MCC standards in instances in which a plan does not meet every element of the Regulation. An employer, plan sponsor or carrier seeking to have a plan deemed MCC compliant as an alternative to self-assessment must complete an MCC Certification Application, found at: <http://mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/Health%2520Care%2520Reform/What%2520Insurance%2520Covers/MCC%2520Background/MCC%2520Certification%2520Application.pdf>

The Connector will review certification materials and may grant an MCC Certification if, in its discretion, it determines that the overall value of the benefits provided by the plan, despite the deviations identified by the applicant, provides sufficiently comprehensive coverage.

For the period beginning January 1, 2010, a health benefit plan will not be granted an MCC Certification if:

- benefit limitations established by the health benefit plan are clearly inconsistent with standard employer-sponsored coverage
- benefit limitations established by the health benefit plan (that are inconsistent with standard employer-sponsored coverage) do not represent innovative ways to improve quality or manage the utilization or cost of services delivered

Actuarial Attestation

MCC Certification requires the overall value of a plan to be equal to or greater than any bronze-level plan (the lowest level of the three coverages: gold, silver and bronze) offered through the Connector. Applicants will be required to state whether they believe that the health benefit plan in question meets this standard, and may eventually be required to submit an actuarial attestation to the Connector so stating. However, an applicant is not required to provide an actuarial attestation with the initial application.

Aggregating Multiple Plans

As an employer or plan sponsor, if the health coverage provided is made up of multiple health benefit plans you should combine the features and determine the aggregate value of the plans in assessing whether, as a whole, the health coverage meets MCC standards. If the plan you are submitting for MCC Certification is composed of several plans (e.g., certain benefits are carved out) you must provide information for all plans that make up your health coverage. Any actuarial attestation submitted must attest to the value of the combined health plans, but need not assess the value of each separate benefit.

Effective Date of MCC Certification

A benefit plan's MCC Certification is valid until there is a material change to the

benefits provided by the plan and/or the Connector Board approves revisions to the Regulation altering MCC standards. A material change is defined as a modification to a plan's benefit design (e.g., a change in covered benefits and/or cost sharing) that relates directly to MCC standards. Material changes to the benefit plan and/or cost sharing that do not impact MCC standards (e.g., the elimination of chiropractic coverage, changes to cost sharing for durable medical equipment), would not require a plan sponsor or carrier to request MCC re-certification.

This Legislative Update provides an overview. For more specific information, visit the following sites:

<http://www.mahealthconnector.org/portal/site/connector/menuitem.d7b34e88a23468a2dbef6f47d7468a0c?iShown=default>

<http://www.mass.gov/?pageID=dorhomepage&L=1&LO=Home&sid=Ador>

Sources: *Massachusetts Commonwealth Health Insurance Connector Massachusetts Dept. of Revenue*

To view our archive of *Mesirow Financial Legislative Updates* and *Looks At* newsletters, please visit:

<http://www.mesirowfinancial.com/benefits/default.jsp>

This article is intended as an overview and should not be viewed as legal or tax advice. Please consult your attorney or tax advisor if you have any questions.

Employer MCC Checklist	Yes/No
Do you have employees who reside in Massachusetts?	
Is your current carrier aware that you have employees in Massachusetts?	
Are your benefits equal to or greater than the MCC standards according to your provider and the Commonwealth of Massachusetts?	
Does your plan document need to be revised?	
Has your plan document been revised?	
If your benefits do not meet MCC, have you filed for a certification?	



Form MA 1099-HC Individual Mandate Massachusetts Health Care Coverage

2009
Massachusetts
Department of
Revenue

1 Name of insurance company or administrator

2 FID number of insurance co. or administrator

3 Name of subscriber

4 Date of birth

5 Subscriber number

6 Street address

7 City/Town

8 State

9 Zip

Full-year minimum creditable coverage? If No, check months with minimum creditable coverage: Corrected:
 Yes No Jan. Feb. Mar. Apr. May June July Aug. Sept. Oct. Nov. Dec.

a. Name of dependent Date of birth Subscriber number

Full-year minimum creditable coverage? If No, check months with minimum creditable coverage: Corrected:
 Yes No Jan. Feb. Mar. Apr. May June July Aug. Sept. Oct. Nov. Dec.

b. Name of dependent Date of birth Subscriber number

Full-year minimum creditable coverage? If No, check months with minimum creditable coverage: Corrected:
 Yes No Jan. Feb. Mar. Apr. May June July Aug. Sept. Oct. Nov. Dec.

c. Name of dependent Date of birth Subscriber number

Full-year minimum creditable coverage? If No, check months with minimum creditable coverage: Corrected:
 Yes No Jan. Feb. Mar. Apr. May June July Aug. Sept. Oct. Nov. Dec.

d. Name of dependent Date of birth Subscriber number

Full-year minimum creditable coverage? If No, check months with minimum creditable coverage: Corrected:
 Yes No Jan. Feb. Mar. Apr. May June July Aug. Sept. Oct. Nov. Dec.

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