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Minimum Creditable Coverage Standards

Minimum Creditable Coverage (MCC) establishes the lowest health plan benefits Massachusetts residents must have in order to meet the requirement to have health insurance.

The following are the core criteria of the MCC requirements, effective January 1, 2009. This is subject to change as clarifications are issued. **View the complete MCC regulations**.

Item	MCC Criteria, Effective January 1, 2009
1.	Coverage under a health benefit plan, or the aggregate of multiple health benefit plans, must provide, in addition to the other requirements of regulation 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 and substance abuse services, in accordance with at least the minimum standards set by state and federal statutes and regulations governing the particular health benefit plan.
2.	A health benefit plan may impose reasonable exclusions and limitations, including different benefit levels for in-network and out-of-network providers.
3.	A health benefit plan may impose varied levels of copayments, deductibles, and co-insurance, provided that: • The plan discloses to covered persons the deductible, copayment, and co-insurance amounts applicable to in-network and out-of-network covered services; • Any deductible for in-network covered services does not exceed $2,000 for an individual and $4,000 for a family. (Please note that coverage may be deemed creditable if an employer offers a higher deductible and self-funds the difference between a $2,000/$4,000 deductible and the higher deductible amount.) • 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).
4.	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 services that do not exceed $5,000 for an individual and $10,000 for a family.

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Item	MCC Criteria, Effective January 1, 2009
5.	A health benefit plan's calculation of any out-of-pocket maximum must include all of the following payments for in-network covered services made by the individual or family: copayments over $100, co-insurance, and deductibles; however, amounts paid for prescription drugs, whether through deductibles, co-insurance, or copayments, need not be considered in calculating the out-of-pocket maximum.
6.	A health benefit plan may not impose an overall annual maximum benefit limitation to all covered services collectively or a maximum benefit based on dollar or utilization that caps covered core services.
7.	A health benefit plan may not impose an indemnity schedule of benefits for covered core services.
8.	A health benefit plan that imposes a deductible for in-network core services must cover preventive care services on an annual basis in one of two ways before imposing a deductible: (1) At least three covered preventive care visits to a physician or other health care provider for an individual and at least six covered visits for a family (2) Covered preventive care is comparable to the Massachusetts Health Quality Partners (MHQP) guidelines. Any preventive care visits covered before the imposition of a deductible may be subject to copayments or co-insurance, provided, however, that such copayments or co-insurance shall be at no greater than the copayments or co-insurance applied by the health benefit plan to primary care or routine physician office visits.
9.	Any health benefit plan must include prescription drugs as a covered benefit and any separate deductible imposed for prescription drug coverage shall not exceed $250 for an individual and $500 for a family.

For 2009, the Following Shall Be Deemed to Be Providing Minimum Creditable Coverage:

- A health benefit plan that is a young adult plan, as defined in M.G.L. c. 176J, section 10
- Any health benefit coverage defined as creditable coverage in M.G.L. c. 111M, section 1(b)-(l)
- Any high-deductible health plan (HDHP) that complies with federal statutory and regulatory requirements for health savings accounts (HSA) under 26 U.S.C. section 223
- Any health arrangement provided by established religious organizations comprised of individuals with sincerely held beliefs
- Commonwealth Care Health Insurance plans, as established by M.G.L. c. 118H

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MCC Changes for 2010

Item	Beginning January 1, 2010, Two Important Changes to MCC Will Take Effect.
1.	All health benefit plans (including HSA-compliant plans) must contain a newly expanded broad range of medical benefits. This expanded list includes: • Ambulatory patient services, including outpatient, day surgery, and related anesthesia • Diagnostic imaging and screening procedures, including X-rays • Emergency services • Hospitalization (including at a minimum, inpatient acute-care services that are generally provided by an acute-care hospital for covered benefits in accordance with the member's subscriber certificate or plan description) • Maternity and newborn care • Medical/surgical care, including preventive and primary care • Mental health and substance abuse services • Prescription drugs • Radiation therapy and chemotherapy
2.	Federally qualified HDHPs (i.e., HSA-compatible) must also meet MCC standards. An HDHP with deductibles exceeding $2,000 individual/$4,000 family and/or out-of-pocket maximums exceeding $5,000/$10,000 for in-network covered services will meet MCC as long as: • The plan includes core services and the broad range of medical benefits listed above, and, as described in items 6, 7, and 8 on the previous page, does not impose an overall annual maximum benefit limitation, does not impose an indemnity fee schedule of benefits, and covers preventive care before imposing a deductible. • Plan sponsors or carriers provide individuals enrolled in an HDHP with access to a health savings account (HSA). Individuals may decide whether or not to open or fund the HSA account.

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