MASSACHUSETTS

Minimum Creditable Coverage Standards Summary

Minimum creditable coverage establishes the lowest health plan benefits Massachusetts residents must have in order to be considered insured and avoid tax penalties.

Regulations defining minimum creditable coverage were established by the Commonwealth Health Insurance Connector Authority Board effective January 1, 2009. Changes to minimum creditable coverage have been made since the requirements were initially established. The following is a **summary** of the key core criteria for minimum creditable coverage requirements that are applicable on January 1, 2014. This is subject to change as clarifications are issued. To view the complete regulations go to: **www.mahealthconnector.org**.

Summary of Minimum Creditable Coverage Criteria Effective on or after **January 1, 2014**

Compliant plans must provide coverage for a broad range of medical services. There must be some level of coverage for:

- 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 which 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 including prenatal care, postnatal care, and delivery and inpatient services for maternity care
- Medical/surgical care, including preventive and primary care
- Mental health and substance abuse services
- Prescription drugs
- Radiation therapy and chemotherapy

A health benefit plan may impose reasonable exclusions including different benefit levels for in-network and out-of-network providers.

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(s) for in-network covered services that is not provided as part of the plan benefits shall not in combination exceed $2,000 for an individual and $4,000 for a family; and
- Any separate deductible imposed for prescription drug coverage shall not exceed $250 for an individual and $500 for a family.

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If a health benefit plan includes deductibles or co-insurance for in-network covered core services (core services defined as: physician services, acute care services, day surgery, and diagnostic procedures and tests), that plan must set out-of-pocket maximums.

- The out-of-pocket maximum for in-network covered services shall not exceed the amounts for Health Savings Account-qualified high-deductible health plans. For 2014 these amounts are $6,350 per individual, $12,700 per family (adjusted to inflation in future years).
- A health benefit plan's calculation of the out-of-pocket maximum for in-network covered services must include any expenditure, including deductibles, co-insurance, copayments for essential health benefits.
- For instances where more than one service provider or vendor is used to administer benefits that are considered essential health benefits (such as prescription drug coverage) and therefore must accumulate toward the out-of-pocket maximum, the plan will be considered compliant if[1]:

  1. The plan complies with the out-of-pocket requirements above for major medical services (excluding for example, prescription drug coverage and pediatric dental coverage).

  2. If a separate out-of-pocket maximum exists for non-major medical services (such as prescription drug coverage and pediatric dental coverage) it cannot exceed the defined amounts for that year. For 2014 these amounts are $6,350 per individual, $12,700 per family (adjusted to inflation in future years).

A health benefit plan:

- May not impose an overall annual maximum benefit limitation for the plan that applies to all covered services collectively.
- May not impose an overall annual maximum benefit limitation based on dollar amount or utilization that caps covered core services, whether individually or collectively, for a year or for any single illness or condition.
- May not impose an overall annual maximum benefit limitation based on dollar amount on prescription drugs.
- May apply maximum benefit limitations to services that are not considered core services at the Health Connector's discretion provided that certain conditions are met.

A health benefit plan may not impose an indemnity schedule of benefits for covered core services.

A health benefit plan must cover preventive health services on an annual basis without imposing a deductible.

A health benefit plan that does not meet the standards for minimum creditable coverage on its own may be combined with additional health benefit plans so that together they satisfy the requirements.
Examples include:

- A plan that excludes prescription drug coverage may be combined with a separate prescription drug only plan.
- A plan that excludes coverage for mental health services may be combined with a separate mental health carve-out.

1. Allowable only for the first plan year beginning on or after January 1, 2014.

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A health benefit plan with deductibles exceeding $2,000 for an individual and $4,000 for a family and /or out-of pocket maximums for in-network covered services that exceed the amounts for Health Savings Account-qualified high-deductible health plans ($6,350 per individual, $12,700 per family in 2014) may be combined with a Health Reimbursement Arrangement so that together the "net" deductible amount (i.e., the annual deductible less the annual Health Reimbursement Arrangement funding) and out-of-pocket maximum satisfy the amounts stated above.

A health benefit plan will meet the standards if it is a high-deductible health plan which:

- Adheres to federal statutory and regulatory requirements and complies with the relevant items stated above.
- The carrier or plan sponsor facilitates access to a Health Savings Account administrator to enable a covered person to establish and fund and a Health Savings Account in combination with a federally compliant high-deductible health plan or,
- The plan sponsor establishes and maintains a Health Reimbursement Arrangement in combination with a federally compliant high-deductible health plan.

For 2014, the Following Meets Minimum Creditable Coverage:

- A catastrophic health plan as defined in 42 U.S.C. § 18022(e);
- Any health benefit coverage defined as "creditable coverage" in M.G.L. c. 111M, section 1(b)-(l);
- Any health arrangement provided by established religious organizations comprised of individuals with sincerely held beliefs;
- Any currently operating U.S. Veterans Administration health care program administered by the U.S. Veteran's Administration;
- Any health plan offered or approved by the Corporation for National and Community Service for members of the AmeriCorps national service network;
- A health benefit plan that does not meet every element of minimum creditable coverage but which the Health Connector has determined:
  - Conforms with the regulatory requirements under 956 CMR 5.00 relating to core services (without limitation) and a "broad range of medical benefits";
  - Does not fail the standards of minimum creditable coverage
  - Has an actuarial value equal or greater than any bronze-level plan offered through the Health Connector as certified by an actuary.

This information is for general informational purposes and is not intended to be interpreted as legal advice.

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