Minimum Creditable Coverage Policies Ratified

Recently the Commonwealth Connector board ratified policies to ensure that health plans in Massachusetts meet specifics standards of health benefits. The purpose of this communication is to summarize the highlights of their decisions and to help you better understand and communicate these decisions to your employees.

When do these new provisions take place?
The provisions take effect on January 1, 2009 except where indicated.

What are the new guidelines regarding co-payments and out-of-pocket expenses?

- Any deductibles, co-payments, and co-insurance levels must be disclosed
- Any deductibles for in-network covered services may not exceed $2,000 for an individual or $4,000 for a family
- Any separate deductible for Rx coverage may not exceed $250 for an individual or $500 for a family
- If a benefit plan includes deductibles and co-insurance for in-network services, out-of- pocket maximums may not exceed $5,000 for an individual or $10,000 for a family.
- Any out-of-pocket maximum must include the following payments for in-network services:
  - Co-payments over $100
  - Co-insurance and deductibles, with the exception of separate co-payments, coinsurance, and deductibles for Rx coverage which do not need to be included in the out-of- pocket maximum

Any change to Annual Maximums? A benefit plan may not impose an overall annual maximum to covered services or an overall annual maximum benefit limitation based on dollar amount or utilization (e.g. number of services) on covered core services.

***Please note**:* The benefit plan **may impose** benefit limitations to non-core services; however, the Connector may determine that beginning **1/1/10**, a benefit Plan does not meet MCC if the benefit limitations are obviously inconsistent with Standard employer sponsored coverage, and the benefit limitations do not represent innovative ways to improve quality or manage utilization or cost.

Are there any changes to Preventive Care policies? Preventive Care is defined as covered services provided by a health benefit plan, including, but not limited to routine adult physical exams, well baby care, prenatal maternity care, medically necessary child or adult immunizations, and routine GYN exams. Preventive care services must be provided annually before the imposition of any deductible for in-network core medical services.

Please note: as of 1/1/2009, the plan must also cover one or the other below::

- 3 individual preventive care visits or 6 family preventive care visits to a physician or other health care provider, ***OR***
- preventive care in accordance with nationally recognized preventive care guidelines that are comparable to the Mass Health Quality Partners' (MHQP) Preventive Care recommendations and guidelines.

What specific dates should I be aware of to assure my health plan meets the standards decided by the Connector board?

Beginning ***1/1/09***, a health plan must provide a “broad range of medical benefits”. They are:

- Preventive and primary care
- Emergency services
- Hospitalization
- Ambulatory patient services
- Prescription drugs
- Mental health and substance abuse services

Beginning ***1/1/10***, a health plan must provide a "broad range of medical benefits" which includes:

- Ambulatory patient services, including outpatient, day surgery and related anesthesia
- Diagnostic imaging and screening procedures, including x-rays
- Emergency services
- Hospitalization (including inpatient acute care)
- Maternity and newborn care
- Medical/surgical care, including preventive and primary care
- Mental health and substance abuse services
- Prescription drugs
- Radiation therapy and chemotherapy

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