COMPLIANCE ALERT

Alliant EMPLOYEE BENEFITS

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CMS Issues Final Benefit and Payment Parameters Regulations for 2020: Group Health Plan Impact

CMS Issues Final Benefit and Payment Parameters Regulations for 2020

On April 18, 2019, the Centers for Medicare and Medicaid Services (CMS) released its final 2020 Notice of Benefit and Payment Parameters rule (BPP rule) along with additional supporting documents. CMS made very few changes from its proposed rule, which was released in January. As has been the case with past BPP rules, the 2020 final rules address wide ranging issues under the Affordable Care Act (ACA) relevant to Exchange operations, the individual and small-group insurance market, SHOPs, Exchange navigators, and the risk adjustment program. Only a few BPP rule changes directly impact larger group health plans and employer plan sponsors. Significant issues for group health plans are addressed below.

Cost-Sharing Limits and the Premium Adjustment Percentage

The final BPP rule confirms ACA cost-sharing limits for essential health benefits under non-grandfathered plans for 2020. The maximum annual out-of-pocket limit on cost-sharing for 2020 is $8,150 for self-only coverage and $16,300 for other than self-only coverage (the individual limit is embedded for those with family coverage). This is a 3.16 percent increase over 2019 (when the limits were $7,900 for self-only coverage and $15,800 for other than self-only coverage). Notably, these increases are based on the "premium adjustment percentage," which is also used to adjust employer Pay or Play penalty amounts.

For 2020, the premium adjustment percentage will increase by 1.29 percent. This is a larger increase than last year (1.125 percent) in part because a change to the methodology in calculating the premium adjustment percentage. This change is important because a higher premium adjustment percentage means a higher annual limit on out-of-pocket costs, a higher required contribution from subsidy-eligible consumers, and an unaffordability percentage under employer plans (meaning individuals with an offer of employer-sponsored coverage would be less likely to be eligible for premium tax credits).

The increase to the premium adjustment percentage and this change in methodology will also result in higher employer mandate penalties relative to 2019. Although the BPP does not address the indexed Pay or Play penalty amounts, based on the 2020 premium adjustment percentage noted above the Pay or Play penalty amounts for 2020 are expected to be *approximately* $2,590 for a failure to offer coverage,[1] and $3,890 for insufficient offers of coverage. IRS should formally announce 2020 penalty numbers shortly, along with adjustments to the percentage of household income used for ACA affordability and affordability safe harbors thresholds (9.86% for 2019).

[1]For employers who fail to offer coverage to substantially all of their full-time employees, this number is multiplied by the total number of full-time employees less 30 to determine the total penalty amount.

Prescription Drugs and Drug Coverage

The final BPP rule had several sections regarding prescription drugs and drug coverage, most of which were not adopted in the final rule. Those proposed changes and their status in the final rule are addressed below:

- **Mid-year formulary changes:** CMS declined to adopt proposed changes which would have allowed insurers in the individual, small group, and large group markets to make certain mid-year formulary changes to (1) add a generic equivalent of a drug that becomes available on the market; and (2) remove the equivalent brand-name drug from the formulary or move the equivalent brand-name drug to a different cost-sharing tier.
- Certain brand-name drugs not considered "essential health benefits" (EHBs) for purposes of annual/lifetime dollar limits: CMS did not finalize a proposal under which plans that cover both a brand-name prescription drug and its generic equivalent could consider the brand-name drug not to be EHB if the generic drug is available and medically appropriate for an enrollee.
- Manufacturer drug coupons excluded from cost sharing limits**:** CMS finalized and adopted the proposed rule to allow issuers to exclude drug manufacturer coupons from the cost sharing limits where a medically appropriate generic drug is available. Drug manufacturers often provide coupons to patients to help reduce their out-of-pocket costs. However counting manufacturer coupons and copay assistance towards a plan's deductible or out-of-pocket limit shifts plan costs quickly to the plan without the participant having paid much of anything actually out of their own pocket. This can skew utilization towards expensive brand drugs and when amounts paid by manufacturers count towards cost sharing limits overall plan costs tend to increase. In response, some insurers and pharmacy benefit managers (PBMs) adopted accumulator adjustment programs. This means the insurer or PBM will not apply a manufacturer's copay assistance or other coupon to an enrollee's deductible or out-of-pocket maximum and the enrollee cannot "count" any of the coupon's value towards their out-of-pocket costs. Beginning with the 2020 plan year, insurers and PBMs can, but do not have to, count any form of direct support from a drug manufacturer towards the deductible or annual maximum limit on out-of-pocket costs if a brand-name drug has a generic equivalent.

For additional questions about the issues addressed in this Alert, please contact your dedicated Alliant team members with questions.

Compliance Alert is presented by the Compliance Practice Group of Alliant Employee Benefits

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