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2020 ACA COST-SHARING CAPS SET, PLAY-OR-PAY PENALTIES PROJECTED

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In This Article

The final Notice of Benefit and Payment Parameters for 2020 adopts many of the Affordable Care Act (ACA) regulatory changes proposed earlier this year by the US Department of Health and Human Services (HHS). These rules primarily affect states and insurers in the private insurance market, but some parameters also apply to large employer-sponsored plans.

ADJUSTMENT METHOD REVISED

HHS annually adjusts the ACA's cost-sharing limits and employer shared-responsibility (ESR) assessments using a specific factor based on insurance premiums. The proposed rules called for changing how this "premium adjustment percentage" is calculated to include premium data not only for employer-sponsored insurance but also for certain types of individual insurance.

Some commenters objected to the new method, questioning its validity and impact on affordability. They argued that including data from a still unstable individual market would result in inaccurate and higher premiums and reduce premium tax credits for anyone purchasing individual insurance.

Despite commenters' concerns, HHS has finalized this change, saying the new calculation method better reflects premium costs across the insurance market. HHS maintains that average premium growth in the private insurance market has stabilized, and the new calculation only slightly increases the premium adjustment percentage over the old method.

The final adjustment factor is 1.2895211380, which will increase two parameters that apply to large employer-sponsored coverage: annual cost-sharing limits and ESR assessments.

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Cost-Sharing Limits for 2020

The final 2020 annual out-of-pocket (OOP) maximums for nongrandfathered group health plans are:

- ***Self-only coverage:*** $8,150
- ***Coverage other than self-only:*** $16,300

These figures represent an increase of 3.16% from the 2019 final cost-sharing limits of $7,900 (self) and $15,800 (other). These limits apply to all OOP costs for in-network essential health benefits.

Projected ESR Assessments for 2020

Applying the final premium adjustment percentage along with the new HHS calculation method, the 2020 play-or-pay assessments for employers are projected to increase to these amounts:

- ***Not offering coverage:*** $2,570 per full-time employee, up from $2,500 in 2019
- ***Offering coverage that is unaffordable or lacks minimum value:*** $3,860 per full-time employee who receives subsidized coverage through a public exchange, up from $3,750 in 2019

IRS typically announces official ESR assessment figures for the upcoming year after HHS finalizes the premium adjustment percentage for that year (Q&A-13 of Notice 2015-87).

Impact on Other IRS Adjustments

If adopted by IRS, the new calculation method will affect several other ACA amounts:

- Increase the required contribution percentage used to determine if an offer of employer-sponsored coverage is affordable
- Increase the portion of the premium that individuals with public exchange coverage will pay
- Reduce the premium tax credit for individuals with public exchange coverage

DRUG COUPON POLICY ADOPTED, OTHER DRUG PROPOSALS TABLED

HHS had proposed several prescription drug policy changes, some designed to promote greater use of lower-cost generic medications. The final rule adopts one of these proposals: When calculating enrollees' OOP costs, nongrandfathered plans — including insured and self-insured large group health plans — can exclude the value of the drug manufacturer coupons used to buy brand-name medications if generic-equivalent drugs are available.

This rule is permissive: Plans do not have to disregard manufacturer coupons or other forms of direct support and can still include those amounts in enrollees' costs when calculating the annual OOP limit. However, state laws may prohibit some insured plans from adopting this approach.

The final rule clarifies that this policy change does not apply when a drug does not have a generic equivalent or a plan's appeals or exceptions process has concluded that a generic equivalent is not available or medically appropriate for the patient.

HHS declined to finalize other drug proposals:

- ***Brand-name drugs with generic equivalents.*** One proposal would have allowed insurers and self-insured health plans that cover both brand-name drugs and their generic equivalents to (i) always calculate OOP costs using the generic cost-sharing amount whenever a generic is available and medically appropriate; and (ii) impose annual and lifetime dollar limits on brand-name drugs. In tabling this proposal, HHS cited concerns raised by commenters, such as greater administrative costs and burdens — including the impact on determining actuarial value — and higher OOP expenses for patients with chronic conditions. For now, plans can continue to rely on informal 2014 guidance in Q&A-3 of the ACA Implementation FAQs, Part XIX, which discussed when a large employer self-insured plan can cover only generics, if medically appropriate and available.

- ***Midyear formulary changes for insured plans.*** Under current federal law, insurers generally can make coverage changes to group health plans only at the time of renewal. HHS had proposed to let issuers in all markets, including the large-group market, make midyear formulary changes to replace brand drugs with new generic equivalents (or shift brand drugs to a higher tier) after 60 days' advance notice to enrollees. HHS will further examine this proposal and its implications for plans and consumers. Some commenters noted that some states already permit midyear formulary changes in several circumstances. However, HHS expects issuers in those states to let individuals appeal or use an exception process to request access to a nonformulary drug. Self-insured ERISA plans are not subject to the ban on midyear changes, although certain notice and other requirements may apply.

- ***Other drug policy proposals.*** HHS received several comments on the pros and cons of alternative drug policies, such as therapeutic substitution and reference-based pricing. Regulators will take these views into consideration when drafting future rule changes.

CONTINUED FOCUS ON DISCRIMINATORY PLAN DESIGN, OPIOID CRISIS

In the proposed rule, HHS noted that the lack of coverage for medication-assisted treatment (MAT) of opioid use disorders has contributed to the opioid crisis. In the final rule, HHS says it will monitor and implement strategies to address discriminatory benefit designs and the opioid epidemic.

Commenters supported HHS's view that unless a plan has supporting documentation, excluding certain drugs or treatments for opioid use disorders but covering the same drugs or treatments for other medically necessary purposes is discriminatory under the ACA's essential health benefit (EHB) rules. Plans — including large insured and self-insured plans — with such designs could violate:

- Parity rules for nonquantitative treatment limitations under Mental Health Parity and Addiction Equity Act (MHPAEA)

- Nondiscrimination requirements under the Americans with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act

ACTIONS FOR PLAN SPONSORS

Employers with nongrandfathered plans will need to update their maximum annual OOP limit for 2020 to $8,150 (self) and $16,300 (other). Employers should also note the slight increase in ESR assessments for 2020, as IRS continues to actively enforce these penalties.

Employers that have yet to evaluate how their plans treat drug coupons when calculating annual OOP limits may want to review those policies. Matters to consider include the impact on not only the plan's expenses, but also participants' out-of-pocket costs and medication adherence. As the federal government continues to focus on addressing the opiate crisis, employers should also evaluate how their plan covers MAT for substance use disorders and whether that policy complies with the ACA, MHPAEA and ADA.

RELATED RESOURCES

Non-Mercer Resources

- HHS Notice of Benefit and Payment Parameters for 2020 (Federal Register, April 25, 2019)
- Press Release: CMS Issues Final Rule for the 2020 Annual Notice of Benefit and Payment Parameters (April 18, 2019)
- Fact Sheet on Final HHS Notice of Benefit and Payment Parameters for 2020 (April 18, 2019)
- Indexing Provision in HHS Proposed Marketplace Regulations Is Not Just Bad Policy, but Could Be Vulnerable to Legal Challenge (Brookings, Feb. 14, 2019)
- Proposed HHS Notice of Benefit and Payment Parameters for 2020 (Federal Register, Jan. 24, 2019)
- Illinois Becomes First and Only State To Change EHB-Benefit Benchmark Plan (IL Ins. Dep't, Aug. 27, 2018)
- FAQs About Affordable Care Act Implementation (Part XIX) (see Q&A 3) (DOL/HHS/IRS, May 2, 2014)

Mercer Law & Policy Resources

- Quick Benefit Facts and COLA Resources for Benefit Plans (April 8, 2019)
- HHS Proposes 2020 Cost-Sharing Limits, ESR Penalties, More EHB Changes (March 1, 2019)

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