2021 ACA out-of-pocket maximums, ESR penalties, other changes ahead

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The final Notice of Benefit and Payment Parameters for 2021 adopts many of the Affordable Care Act (ACA) regulatory changes proposed earlier this year by the US Department of Health and Human Services (HHS). The notice addresses federal standards that will apply to the private insurance market starting in 2021, including some affecting employer-sponsored plans. The wide-ranging regulation provides the adjustment factor that determines the 2021 ACA cost-sharing limits — or out-of-pocket (OOP) maximums — and employer shared-responsibility (ESR) assessments. The notice also clarifies the treatment of drug manufacturer coupons when tracking the ACA's OOP maximums and addresses health reimbursement arrangements (HRAs). Other changes to how insurers calculate medical loss ratios (MLRs) and how states report on essential health benefits (EHBs) could have some indirect effects on employer-sponsored plans.

Final adjustment factor for 2021 payment parameters

HHS determines the annual adjustment to the ACA's in-network OOP maximums and ESR assessments. HHS adjusts these parameters using the "premium adjustment percentage," which reflects the growth in the average per capita private health insurance premium since 2013. The final premium adjustment percentage for 2021 is 1.3542376277.

2021 ACA in-network OOP maximums

Using the final premium adjustment percentage, the 2021 ACA in-network OOP maximums for EHBs under nongrandfathered group health plans are:

- **Self-only coverage:** $8,550
    - This amount is also the embedded individual in-network OOP maximum for family coverage. Self-insured and large-group insured nongrandfathered health plans must embed an individual in-network OOP maximum in any coverage tier broader than self-only that has a family OOP limit greater than the ACA-required self-only OOP limit.
- **Coverage other than self-only:** $17,100

These figures represent a 4.9% increase from the 2020 OOP maximums of $8,150 (self) and $16,300 (other). The limits apply to all OOP costs for in-network EHBs provided by nongrandfathered plans.

As IRS announced in May (Rev. Proc. 2020-32), high-deductible health plans (HDHPs) qualifying to work with health savings accounts (HSAs) have 2021 in-network OOP maximums — $7,000 for self-only and $14,000 for other coverages — lower than the ACA limits.

2021 ESR assessments projected

The premium adjustment factor is also applied to adjust the required contribution percentage that employers use to determine the affordability of coverage for ESR compliance. Although IRS has not yet officially announced the 2021 adjusted amounts, by applying the final premium adjustment percentage, Mercer has projected the 2021 ESR assessments:

- **Employers not offering coverage:** $2,700 per full-time employee (a 5.1% increase from the $2,570 amount for 2020)
- **Employers offering coverage that is unaffordable or lacks minimum value:** $4,060 per full-time employee who receives subsidized coverage through a public exchange (a 5.2% increase from the $3,860 amount for 2020)

IRS is expected to announce the 2021 assessment amounts in regularly updated Q&As (#55) about ACA's ESR requirements posted on the agency's website.

Flexibility in treatment of drug manufacturer coupons

The final notice clarifies the treatment of drug manufacturers' direct cost reductions, including coupons, when tracking the ACA's in-network OOP maximum under nongrandfathered plans. Unless state law

provides otherwise, group health plans and insurers can — *but are not required to* — count toward the OOP maximum any form of direct cost reductions, including coupons, that drug manufacturers offer to enrollees purchasing specific medications. This is the case even if the manufacturer support is for a drug without any medically appropriate generic equivalent, such as a specialty drug.

As a result, plans and issuers have flexibility to determine whether to include or exclude drug manufacturers' direct support from the ACA's OOP maximum, regardless of whether a medically appropriate generic equivalent is available. This should ease some compliance concerns about so-called copay accumulator programs and other pharmacy benefit manager (PBM) arrangements devised largely to address the rising costs of specialty drugs. However, other federal regulations and/or state laws might limit how the OOP maximum rule applies:

- **HSA/HDHP rules.** Counting drug coupons toward the OOP maximum for an HSA-qualifying HDHP will raise compliance concerns. Section 223 of the tax code and Q&A-9 in IRS Notice 2004-50 provide that HDHPs may credit toward the minimum annual deductible only an individual's true economic cost for a covered benefit. However, drug discount cards do not disqualify the recipient from HSA eligibility, as long as the individual still has to pay drug costs (after any discount) and most other healthcare expenses until the HDHP deductible is met. The final HHS notice refers to this IRS guidance and says that HDHPs must disregard any third-party rebates or discounts — whether from a discount card or a drug coupon — in determining whether an individual has satisfied the deductible. As a result, plan sponsors may opt to have drug coupons accumulate toward an HDHP's OOP maximum, but cannot count those amounts toward the HDHP's annual deductible.

- **State laws.** Plan sponsors with insured arrangements should note that federal law generally does not preempt more stringent state regulations in this area. A handful of states require that insurers apply drug coupons to the OOP maximum in certain situations. Some states might require insurers not to count these amounts when generics are available. Insured group health plans will have to comply with the applicable state law.

No new notice required. Regardless of how plans choose to apply drug coupons to the OOP maximum, HHS encourages plans to prominently include this information in communications to enrollees. Although the HHS rule does not impose any new requirement to explain how drug coupons are treated, ERISA disclosure requirements arguably apply, as well as any state insurance disclosure rules for insured arrangements.

Health reimbursement arrangements

A 2019 regulation allows employers to sponsor two new types of health reimbursement arrangements (HRAs): individual-coverage HRAs and excepted-benefit HRAs. These variations join a third type, qualified small-employer HRAs (QSEHRAs), enacted by the 21st Century CURES Act (Pub. L. No. 114-255). (For details on QSEHRA requirements, see IRS Notice 2017-67.)

Through guidance and outreach to employers, the administration has focused on how employers can use these new HRAs as a mechanism to provide tax-free coverage for certain employees. Earlier this year, HHS released guidance on the process for states to restrict excepted-benefit HRAs from reimbursing short-term, limited-duration insurance premiums. HHS also has been holding webinars for employers on individual-coverage HRAs. In the meantime, IRS is responsible for finalizing rules on how individual-coverage HRAs interact with the ACA's ESR requirements and the nondiscrimination rules for self-funded group health plans under Section 105(h) of the Internal Revenue Code.

The final HHS notice includes two technical rules for excepted-benefit HRAs sponsored by state and local governments and for QSEHRAs with noncalendar plan years.

Notice for state and local government excepted-benefit HRAs

The 2019 regulations for excepted-benefit HRAs noted that existing ERISA notice rules require informing participants about how this new type of HRA works. However, ERISA does not apply to plans sponsored by state and local government employers, leaving these plans without any notice requirements for excepted-benefit HRAs. HHS has addressed that omission in the final rule for 2021.

Effective for plan years starting on or after Jan. 11, 2021, state and local government employers sponsoring excepted-benefit HRAs must follow notice requirements similar to ERISA's notice rules. The notice must include information about eligibility for the excepted-benefit HRA, annual or lifetime caps and other coverage limits, and a description of the benefit.

Plans must provide the notice within 90 days after an employee becomes a participant and annually thereafter. Plans must distribute the notice "in a manner reasonably calculated to ensure actual receipt," but HHS does not restrict the use of electronic delivery.

Special enrollment for noncalendar-year QSHERAs

While HRAs are generally considered group health plans, the law specifically bars treating QSEHRAs as group health plans. As a result, the rules allowing anyone with an individual-coverage HRA that has a noncalendar plan year (starting on a date other than Jan. 1) to special enroll in individual insurance outside of the normal open enrollment period have not applied to QSEHRAs.

The final HHS notice amends existing special enrollment rules so individuals and their dependents enrolled in QSEHRAs with noncalendar plan years can special enroll in individual insurance — on or off the public exchanges — that aligns with the start date of the noncalendar-year plan. As a result, individuals with noncalendar-year QSEHRAs will be able to use a special enrollment period to enroll in or change to different individual health insurance. This is likely effective for plan years starting in 2021 or later.

Changes to insurers' MLR calculations and states' EHB reporting

Two new compliance obligations for insurers and states could have some indirect impact on large employer plan sponsors. One change affects how insurers account for drug rebates and other price concessions in MLR calculations. The other change modifies how states report on EHBs and state-mandated benefits.

MLR change on PBM drug rebates

Under the ACA's MLR rules, insurers must spend a minimum percentage of their premiums on providing healthcare and related quality activities or pay a rebate to the insurance policyholder. Employers receiving a rebate as an insured plan's policyholder then have to determine whether the rebate is a plan asset that they must share with participants.

Under current rules, an insurer must report and deduct from its MLR incurred claims only drug rebates or other price concessions it receives and retains, not any received and retained by its PBMs. Under the final notice, an insurer will also have to reduce its MLR incurred claims by any drug rebates and other price concessions received and retained by PBMs that provide services to the insurer.

Insurers will also have to report the rebates and price concessions received and retained by PBMs as nonclaim costs. HHS estimates this change will increase MLR rebates paid to individual and employer policyholders by more than $18 million annually.

These changes won't take effect until the 2022 MLR reporting year (with reports filed in 2023).

EHB reporting

Although EHB rules don't apply to large employer plans, those plan sponsors still must choose a state benchmark plan to use for identifying EHBs subject to the ACA's ban on annual and lifetime dollar limits and the law's in-network OOP maximums for nongrandfathered plans. As a result, changes in the EHB rules could affect the state benchmark plan that a large employer uses to meet its ACA compliance obligations. In addition, states can now change their benchmark from year to year.

Under existing EHB rules, mandated benefits resulting from state actions after Dec. 31, 2011, are not considered EHBs (even if included in a state's benchmark plan), unless those benefits are required under federal law. States and insurers have to account and pay for the additional costs of these mandated benefits.

To better track this requirement and enhance transparency, HHS will require that states annually report which mandated benefits don't count as EHBs and which ones are EHBs. States must make their first

annual submission of this information to the Centers for Medicare & Medicaid Services (CMS) by July 1, 2021. CMS will make this information available to the public on its website.

This transparency may prove helpful for large employers that consult the CMS website to determine which benefits are EHBs in each state. However, information on the CMS website is not always clear or up-to-date. Depending on how the new reporting requirement is implemented, it may give employers better information about which benefits in a state benchmark are EHBs.

Value-based purchasing

The final notice includes voluntary standards to promote value-based insurance designs (VBIDs) for qualified health plans (QHPs). Although this initiative only affects QHP insurers, employers may want to stay informed about value-based models that could become available as part of the Trump administration's push for cost-effective plan designs and transparency in cost and coverage.

VBID examples. The notice includes examples of high-value services and drugs with evidence of clinical effectiveness for most patients, such as glucometers and testing strips for diabetes, antidepressants, and buprenorphine-naloxone. HHS encourages insurers to consider offering these high-value items with lower or zero cost sharing. The notice also lists low-value services — such as proton beam therapy for prostate cancer, vitamin D testing, and nonpreferred branded drugs — for which clinical evidence suggests few consumers would see a clinical benefit. For those items, HHS advises insurers to consider higher cost sharing.

Voluntary adoption. HHS encourages but does not require insurers to adopt VBID designs for QHPs. Insurers have discretion to design cost-sharing structures, subject to ACA's actuarial-value requirements and nondiscrimination rules.

Employer issues

As employers begin preparing for the 2021 plan year, here are some items in the final notice to take into consideration:

- Note the 2021 ACA in-network OOP maximums in plan design and budget planning.
- Consider how the flexibility on accounting for drug coupons and OOP maximums affects your current prescription drug program. This policy aims to reduce the market distortion that could result if discounts steer participants to pricey brand-name drugs over equally effective generics. Plan sponsors should consider how their current program incentivizes generic drug use in deciding whether to count drug coupons toward OOP maximums.

- Plan sponsors that participate in copay accumulator programs should have a clear understanding of how they work and communicate this to participants and beneficiaries. For many people, the cost of prescription drugs is one of the most significant household expenditures. Individuals choosing coverage need better ways to project their annual expenses for certain medications. The current template for the summary of benefits and coverage (SBC) requires plans to answer the question, "What is not included in the out-of-pocket limit?" This would be a good place to mention whether the plan does or doesn't count drug coupons toward the OOP maximum and/or deductible. Employers will also need to amend plan documents to indicate how drug coupons are treated.

- The final notice does not address indirect patient-assistance payments, such as crowdfunding amounts, durable medical equipment manufacturer support or waived medical debt. HHS has found no evidence that these forms of support create the same market distortions as drug coupons, but the agency is monitoring trends. Plans should stay informed about third-party and other payments that impact plan design and enrollee choices.

- State and local governmental plans with excepted-benefit HRAs need to send out notices about those HRAs for plan years beginning on or after Jan. 11, 2021. Sponsors of QSEHRAs operating on a noncalendar-year should make participants and beneficiaries aware that they will be able to special enroll in or change their individual insurance on a noncalendar-year basis to align with the QSEHRA's plan year.

- Insured plan sponsors should recognize that the revised MLR rules may increase the size of MLR rebates. Even without the MLR rule change, the private insurance market's improved financial performance and stabilization means insurers will likely pay out a record amount in MLR rebates later this year, according to a recent data note from the Kaiser Family Foundation. Employers with insured plans should brush up on 2011 Labor Department guidance on how to treat carrier rebates that are ERISA plan assets. Similar rules apply to the rebates or refunds some insurers are now issuing due to the COVID-19 pandemic.

- Plans should look for updated CMS information on state EHB benchmarks starting late next year.

Related resources

Non-Mercer resources

- Rev. Proc. 2020-32 (IRS, May 20, 2020)

- Final HHS Notice of Benefit and Payment Parameters for 2021 (Federal Register, May 14, 2020)

- Press release on final notice (HHS, May 7, 2020)

- Fact sheet on final notice (HHS, May 7, 2020)
- Data note: 2020 medical loss ratio rebates from the (Kaiser Family Foundation, April 17, 2020)
- Insurance bulletin: Procedural guidance for states to recommend restricting certain excepted-benefit HRAs from reimbursing premiums for short-term, limited-duration insurance (CMS, April 7, 2020)
- Proposed HHS Notice of Benefit and Payment Parameters for 2021 (Federal Register, Feb. 6, 2020)
- Final regulation: HRAs and other account-based group health plans (Federal Register, June 20, 2019)
- Notice 2017-67 (IRS, Nov. 7, 2017)
- Pub. L. No. 114-255, 21st Century Cures Act (Congress, Dec. 13, 2016)
- Technical Release 2011-04, Guidance on rebates for group health plans paid pursuant to the medical loss ratio requirements of the Public Health Service Act (Labor Department, Dec. 2, 2011)
- Notice 2004-50 (IRS, Aug. 9, 2004)
- Q&As on ESR provisions under the ACA (IRS, regularly updated)
- EHB benchmark plans (CMS, regularly updated)

Mercer Law & Policy resources

- 2021 health savings account, high-deductible health plan figures set (May 20, 2020)
- Healthcare law and policy outlook for 2020 (Feb. 18, 2020)
- 2020 quick benefit facts (Jan. 27, 2020)
- IRS outlines how individual-coverage HRAs can meet ACA employer mandate (Oct. 29, 2019)
- Agencies ease ACA rule on drug coupons and out-of-pocket costs (Sept. 3, 2019)
- Final rules ease restrictions on health reimbursement arrangements (June 14, 2019)

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