Final 2021 Benefit Payment and Parameters Rule

The Centers for Medicare & Medicaid Services (CMS) released a final rule for benefit payment and parameters for 2021.

According to CMS, the final rule is intended to reduce fiscal and regulatory burdens associated with the Patient Protection and Affordable Care Act (ACA) across different program areas and to provide stakeholders with greater flexibility.

Although the final rule would primarily affect the individual market and the Exchanges, the final rule addresses the following topics that may impact employer-sponsored group health plans:

- Notice requirements for excepted benefit health reimbursement arrangements (EBHRAs)
- Special enrollment period for non-calendar year qualified small employer health reimbursement arrangements (QSEHRAs)
- Maximum annual limitation on cost sharing for plan year 2021
- Cost-sharing requirements and drug manufacturers' coupons

The final rule is scheduled to be published in the Federal Register on May 14, 2020, and will become effective on July 13, 2020.

The 2021 open enrollment period will run from November 1, 2020, to December 15, 2020.

Notice requirements for excepted benefit HRAs

CMS establishes notice requirements for EBHRAs offered by non-federal governmental plan sponsors/employers. Under the final rule, non-federal governmental plan sponsors/employers are required to provide a notice to EBHRA-eligible participants that contains specified information about the benefits that are available under the EBHRA. The notice is required to include a description of the conditions for eligibility to receive benefits under the EBHRA, a description of annual or lifetime limits on benefits, and description or summary of the benefits available under

the EBHRA (similar to what is required in a summary plan description (SPD), but the final rule provides that the notice does not necessarily have to include all of the information that is required to be in an SPD). Under the final rule, the notice must be provided in a manner reasonably calculated to ensure actual receipt by participants who are eligible for the EBHRA (for example, providing notice in the same manner as the employer provides other notices or plan documents). The notice is required to be provided no later than 90 days after the employee becomes enrolled in the EBHRA, and annually thereafter. On an annual basis, the notice is required to be provided no later than 90 days after the first day of the EBHRA plan year.

This rule applies to EBHRAs offered by non-federal governmental plan sponsors/employers for plan years beginning on or after January 9, 2021.

Special enrollment period for non-calendar year QSEHRA participants

CMS establishes a new special enrollment period for individuals enrolled in non-calendar year QSEHRAs to purchase individual coverage on or off the Exchanges (also referred to as Marketplaces). Under the final rule, the special enrollment period occurs annually for employees and their dependents in coordination with the beginning of the QSEHRA plan year and allows the QSEHRA participants to change to other individual health insurance coverage outside of open enrollment for individual coverage offered on or off the Exchanges.

Maximum annual limitation on cost sharing for plan year 2021

CMS provides that the 2021 maximum annual limitation on cost sharing is $8,550 for self-only coverage and $17,100 for other than self-only coverage.

Cost sharing requirements and direct support from drug manufacturers

CMS provides that, to the extent consistent with applicable state law, amounts paid toward reducing the cost sharing incurred by an enrollee using any form of direct support offered by drug manufacturers to enrollees for specific prescription drugs are permitted, but not required, to be counted toward the annual limitation on cost sharing. For example, issuers of non-grandfathered individual and group market coverage, and all non-grandfathered group health plans have discretion to determine whether to include or exclude coupon amounts from the annual limitation on cost sharing, regardless of whether a generic equivalent is available. CMS did not finalize rules regarding the treatment of other types of support (such as crowdfunding amounts, waived medical debt, or support toward the purchase of durable medical equipment) for cost sharing purposes.

CMS encourages issuers to prominently include information on the way direct support from drug manufacturers to enrollees will be treated for cost sharing purposes on websites, brochures, plan summary documents, and other material that consumers may use to select and understand their benefits.

CMS also clarifies that issuers and group health plans have discretion when determining how direct support from drug manufacturers accrues towards accumulators. CMS encourages issuers and group health plans to consider excluding direct support from drug manufacturers from being counted toward the annual limitation on cost sharing.

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