FYI®
For Your Information®

Volume 43

Issue 44

July 29, 2020

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HHS finalizes 2021 out-of-pocket maximums and treatment of prescription drug coupons

The Department of Health & Human Services has set the 2021 out-of-pocket maximums for non-grandfathered plans at $8,550 for self-only coverage and $17,100 for other than self-only coverage. In addition, HHS has finalized rules on how cost-sharing amounts individuals paid for brand-name drugs using drug manufacturers' coupons are applied towards a plan's out-of-pocket maximums.

Background

Each year, the Department of Health & Human Services (HHS) releases the HHS Notice of Benefit and Payment Parameters (NBPP), which includes important guidance on the Affordable Care Act (ACA) marketplaces and various ACA provisions. On May 7, HHS released the final rule for 2021 and a Fact Sheet that summarizes its most significant elements. While primarily focused on the ACA marketplaces and insurers offering programs, the rule also includes guidance affecting large employer and self-insured group health plans.

Out-of-pocket maximums

The ACA imposes annual out-of-pocket (OOP) maximums on the amount that an enrollee in a non-grandfathered health plan, including self-insured and large group health plans, must pay for essential health benefits (EHB) through cost-sharing. (See our February 27, 2013 *FYI*.) These limits are subject to adjustment annually based on a "premium adjustment percentage" determined each year by HHS.

Caution for high-deductible health plans

High-deductible health plans intended to be HSA-compatible are subject to lower OOP maximums — the 2021 limits are $7,000 for self-only coverage and $14,000 for other than self-only coverage. (See our May 26, 2020 *FYI*.)

Based on its premium adjustment percentage for 2021, the 2021 OOP maximums will be $8,550 for self-only coverage and $17,100 for other than self-only coverage. This represents an approximately 4.9% increase over 2020 OOP limits, which were $8,150 for self-only coverage and $16,300 for other than self-only coverage.

What's the "premium adjustment percentage"?

The "premium adjustment percentage" is the percentage (if any) by which the average per capita premium for health insurance coverage for the preceding calendar year exceeds such average per capita premium for health insurance for 2013.

The "premium adjustment percentage" is used to determine changes to:

- Annual OOP maximums
- Employer shared responsibility assessment amounts
- Premium tax credit affordability thresholds

Treatment of brand-name drugs

Generally, all prescription drugs covered by a plan are considered to be EHBs. This means that not only does an individual's cost-sharing for those drugs count toward the applicable out-of-pocket maximum, but the plan cannot impose any annual or lifetime dollar maximum on the drugs. In 2019, HHS finalized rules providing that effective for plan years beginning in 2020, group health plans and issuers would not be required to count cost-sharing amounts paid through the use of drug manufacturer coupons for specific prescription brand drugs towards satisfaction of the OOP maximum if the drug had an available and medically appropriate generic equivalent. The rules did not address how discounts for brand-name drugs should be treated when a generic equivalent was *not* available. (See our June 12, 2019 *FYI*.) HHS subsequently delayed enforcement of this rule. (See our *FYI Alert* from August 30, 2019.)

The final NBPP revises the 2019 rule to give group health plans and issuers more flexibility in determining whether to count cost-sharing amounts paid through the use of drug manufacturer coupons towards satisfaction of the annual OOP maximum. Under the final rule, these amounts may be excluded, regardless of whether a medically appropriate generic equivalent is available. Consistent with this, HHS interprets the definition of cost-sharing as not including expenditures covered by drug manufacturer coupons.

ACA indexed dollar amounts

The table below summarizes the ACA indexed dollar limits for 2021 and prior years.

ACA indexed dollar amounts							
	Out-of-pocket maximums (1,8)		PCORI fee (2,5)	Health FSA salary reduction cap (3,8)	Employer shared responsibility annual assessments (1,4,6,7)		
	Self-only	Other than self-only			4980H(a) – Failure to offer coverage	4980H(b) – Failure to offer affordable, minimum value coverage	Affordability threshold under 4980H(b)
2021	$8,550	$17,100	Not available	Not available	Not available	Not available	Not available
2020	$8,150	$16,300	Not available	$2,750	$2,570	$3,860	9.78%
2019	$7,900	$15,800	$2.54	$2,700	$2,500	$3,750	9.86%
2018	$7,350	$14,700	$2.45	$2,650	$2,320	$3,480	9.56%
2017	$7,150	$14,300	$2.39	$2,600	$2,260	$3,390	9.69%
2016	$6,850	$13,700	$2.26	$2,550	$2,160	$3,240	9.66%
2015	$6,600	$13,200	$2.17	$2,550	$2,080	$3,120	9.56%
2014	$6,350	$12,700	$2.08	$2,500	$2,000	$3,000	9.50%
2013	N/A	N/A	$2.00	$2,500	N/A	N/A	N/A
2012	N/A	N/A	$1.00	N/A	N/A	N/A	N/A

Notes:
(1) Indexed to increase in average per capita premium for U.S. health insurance coverage in prior calendar year. Out-of-pocket maximum does not apply to grandfathered plans or retiree-only plans
(2) Indexed to increases in national health expenditures
(3) Indexed for CPI-U
(4) One-twelfth of annual amount assessed on monthly basis. No assessments for 2014
(5) Applicable dollar amount affected by when plan year ends. No assessment for plan years ending on and after October 1, 2029
(6) Applies on a calendar year basis
(7) Affordability threshold adjusted consistent with Code Section 36B(b)(3)(A)(i)
(8) Applies on a plan year basis
N/A Not applicable

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