Final 2020 Benefit Payment and Parameters Rule

The Centers for Medicare & Medicaid Services (CMS) released its final rule and fact sheet for benefit payment and parameters for 2020.

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

- Small Business Health Options Program (SHOP)
- Prohibition against discrimination
- Maximum annual limitation on cost sharing for plan year 2020
- Cost-sharing requirements and drug manufacturers' coupons

The final rule is scheduled to be published on April 25, 2019. If it is published on April 25 as scheduled, then the final rule will be effective on June 24, 2019. The final rule generally applies to plan years beginning on or after January 1, 2020.

The 2020 open enrollment period will run from November 1, 2019, to December 15, 2019.

Small Business Health Options Program (SHOP)

Under the final rule, CMS allows Federally Facilitated Small Business Health Options Programs (FF-SHOPs) to operate a toll-free hotline and eliminates the requirement that FF-SHOPs operate a more robust call center.

The toll-free hotline provided by such FF-SHOPs must consist of a toll-free number linked to interactive voice response capability, including prompts to pre-recorded responses to frequently asked questions, information about locating an agent and broker in the caller's area, and the ability for the caller to leave a message regarding any additional information needed.

Prohibition against discrimination

In the final rule, CMS discusses the nationwide opioid public health emergency and encourages every health insurance plan to provide comprehensive coverage of medication-assisted treatment (MAT), even if the applicable essential health benefit (EHB) benchmark plan does not require the inclusion of all four MAT drugs on a formulary.

The final rule discusses, at length, the potential for discrimination in plan design. It states that an issuer does not provide EHBs, under the ACA's prohibition against discrimination, if the plan's benefit design, or the implementation of its benefit design, discriminates based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions.

The final rule reminds issuers that any indication of a reduction in the generosity of a benefit in some manner for subsets of individuals that is not based on clinically indicated, reasonable medical management practices is potentially discriminatory.

For any EHB, issuers are expected to impose limitations and exclusions on the coverage of benefits to treat opioid use disorder (including the drugs used for MAT), based on clinical guidelines and medical evidence, and are expected to use reasonable medical management. If a plan excludes a certain opioid use disorder treatment but covers the same treatment for other medically necessary purposes, the issuer must be able to justify such an exclusion with supporting documentation explaining how such a plan design is not discriminatory.

CMS notes that a similar standard is imposed under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). Under MHPAEA's regulations, if a drug is offered under a plan for treatment of a medical condition but is excluded for MAT purposes, then it is considered to be a nonquantitative treatment limitation.

CMS explains that the issuer must demonstrate that, as written and in operation, the processes, strategies, evidentiary standards, and other factors it applied in deciding that the drug is covered for medical/surgical purposes, are comparable to those it used in deciding that the drug is not covered for MAT purposes, and that there are no limitations that apply only for mental health or substance use disorder benefits.

CMS also notes that federal civil rights laws, such as Title II of the Americans with Disabilities Act and Section 504 of the Rehabilitation Act, prohibit discrimination against individuals who participate in or have completed substance use disorder treatment, including MAT.

Maximum annual limitation on cost sharing for plan year 2020

Under the final rule, the 2020 maximum annual limitation on cost sharing is $8,150 for self-only coverage and $16,300 for other than self-only coverage.

Cost sharing requirements and drug manufacturers' coupons

Under the final rule, the amounts paid toward cost sharing using any form of direct support offered by drug manufacturers (for example, coupons) to insured patients to reduce or eliminate immediate out-of-pocket costs for specific prescription brand drugs that have a generic equivalent are not required to be counted toward the annual limitation on cost sharing.

The final rule clarifies that where there is no generic equivalent available or medically appropriate, or when it is determined through an appeals process or under the drug exception process that a brand drug is required, the amounts paid toward cost sharing using any form of direct support offered by drug manufacturers must be counted toward the annual limitation on cost sharing. This final rule applies to the extent that it is consistent with state law.

This permissive cost sharing restriction applies to plan years beginning on or after January 1, 2020.

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