Benefits Alert: HHS Final Rule Addresses Application of Prescription Drug Copay Coupons to Group Health Plan Out-of-Pocket Limit

Related Attorneys

Jacquelyn Meng Abbott

Dawne McKenna Parrish

Christine M. Poth

Jennifer Bibart Dunsizer

Related Services

Employee Benefits and Executive Compensation

Labor and Employment

CLIENT ALERT | 5.13.2020

On May 7, 2020, HHS announced a final rule in the HHS Notice of Benefit Parameters for 2021 (to be published in the Federal Register on May 14, 2020) (the 2021 Final Rule) that addresses the application of prescription drug manufacturer copay coupons to a group health plan out-of-pocket limit. Under the final rule, a group health plan may, but is not required to, exclude the value of prescription drug copay coupons from a participant's out-of-pocket limit.

Under the 2021 Final Rule, a self-funded group health plan has the flexibility to determine whether to include or exclude the amount of drug manufacturer copay coupons regardless of whether a medically appropriate generic equivalent is available. An insured group health plan may also have to comply with any applicable state laws regarding copay coupons.

The 2021 Final Rule differs from the 2020 final rule that permitted plans to exclude the value of prescription drug manufacturer copay coupons from a participant's out-of-pocket limit *only* when the prescription drug had a medically appropriate generic equivalent available. Enforcement of the 2020 final rule was placed on hold pending publication of the 2021 Final Rule.

The enforcement suspension of the 2020 final rule occurred because the Tri-Agencies (HHS, DOL, IRS) determined that plan sponsors who complied with the 2020 final rule could simultaneously cause participants enrolled in HSA-compatible high deductible plans (HDHP) to become ineligible to make or receive HSA contributions. According to the preamble to the 2021 Final Rule, there is no requirement that individuals covered by an HDHP *exclusively* pay for medical expenses they incur before meeting the deductible (and so, for example, family members may provide assistance as a gift to the individual, which may include paying for medical expenses on behalf of the individual). However, according to the preamble, the result is different if a third party is involved in the provision of a service or product that results in the medical expense, such as a drug manufacturer or hospital, that has arranged for a rebate or discount to such individual.

Unless new guidance is issued by the IRS changing its current position that discounts must be disregarded in determining whether a HDHP deductible has been met, it appears that sponsors of HSA-compatible HDHPs must adopt a copay accumulator program in order to preserve participants' eligibility to make or receive health savings account (HSA) contributions. A copay accumulator program tracks participants' use of prescription drug copay coupons and prevents the prescription drug copay coupons from being credited toward a participant's deductible and out-of-pocket limit.

Plan sponsors will need to determine whether a copay accumulator program is needed based on their plan design. If a copay accumulator program is needed, plan sponsors should discuss implementation with their pharmacy benefit manager (PBM) and/or review current arrangements with their PBM to determine that the copay accumulator program will track drug manufacturer copay coupons and other third party discounts. Plan sponsors should also describe the copay accumulator program in a summary of material modifications (often included in annual enrollment materials) and in a summary plan description.

Please contact your Vorys benefits attorney for more information regarding copay accumulator programs and the steps needed to document them in your group health plans. For background on copay accumulator programs, see our October 24, 2019 *Benefits Alert*: The Uncertain Status of Copay Accumulator Programs.