

HHS Finalizes 2025 Benefit and Payment Parameters, Issues FAQ (Part 66) on EHB Prescription Drug Requirements

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Final Rule: PPACA, HHS Notice of Benefit and Payment Parameters for 2025; Updating Section 1332 Waiver Public Notice Procedures; Medicaid; Consumer Operated and Oriented Plan (CO-OP) Program; and Basic Health Program, 31 CFR Part 33; 42 CFR Parts 435 and 600; 45 CFR Parts 153, 155 and 156, 89 Fed. Reg. __ (__, __); Fact Sheet: HHS Notice of Benefit and Payment Parameters for 2025 Final Rule (Apr. 2, 2024); FAQ About Affordable Care Act Implementation Part 66 (Apr. 2, 2024)

[Regulations](#)

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[FAQ](#)

HHS has finalized regulations that amend and refine several benefit payment parameters and other Affordable Care Act (ACA) insurance market and Exchange related rules for 2025. The regulations address a wide range of standards that are primarily of interest to insurers and Exchanges. For instance, multiple amendments aim to streamline the Exchange enrollment process, including an extension of the special enrollment period under which Exchanges can allow consumers with household incomes at or below 150% of the federal poverty level to enroll in coverage in any month, rather than only during an Exchange open enrollment period. Another provision allows states to add routine adult dental services to essential health benefits (EHBs) starting in 2027.

Notably, the regulations and a contemporaneously issued FAQ also clarify certain EHB prescription drug requirements that may impact employer-sponsored group health plans. The regulations codify the HHS policy that prescription drugs that a plan covers in excess of those covered by a state's EHB-benchmark plan are considered EHBs and are subject to the annual limitation on cost-sharing and the prohibition on annual and lifetime dollar limits, unless the coverage of the drug is subject to a state mandate. The provision applies only to non-grandfathered individual and small group market coverage that is subject to the requirement to provide EHBs. The FAQ clarifies that the regulation does not address the policy's application to large group market and self-insured health plans and indicates that the agencies intend to propose rulemaking that would also require these plans to treat prescription drugs covered by the plan or in excess of the applicable EHB benchmark as EHBs for purposes of the annual limitation on cost-sharing and the prohibition on annual and lifetime limits.

EBIA Comment: Some health plans do not cover the cost of certain drugs above a specified threshold. This design may be used to limit the plan's exposure to costs and encourage covered individuals to take advantage of need-based drug assistance programs sometimes offered by drug manufacturers. Under "copay maximizer" programs, once the minimum number of drugs in an EHB-benchmark plan's classification or category is covered, the plan treats additional drugs in the class or category as non-EHBs, and the out-of-pocket maximum is not applied to copays for those drugs. For small group coverage, drug coverage in excess of its EHB-benchmark plan is now clearly subject to the out-of-pocket maximum. And for large group and self-insured health plans, it appears to be only a matter of time before the same rule applies. For more information, see EBIA's Health Care Reform manual at Sections IX.B ("Cost-Sharing Limits") and XXI.A.3 ("Annual and Special Enrollment Periods Required for Exchanges"). See also EBIA's Self-Insured Health Plans manual at Sections XV.D ("Designing Cost-Sharing Features") and XI.E ("Trends in Self-Insured Health Plan Design").

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