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Discriminatory Copay Policies Undermine Coverage for People with Chronic Illness

COPAY ACCUMULATOR ADJUSTMENT POLICIES IN 2022

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Introduction

Patients with rare, complex, or chronic diseases such as HIV and hepatitis C often need high-cost specialty medications to manage their conditions and maintain their health. Over the past decade, insurance companies have increasingly shifted the cost of these specialty medications to patients by raising deductibles and the amounts of copayments or coinsurance that patients must pay when they buy their medications.

As a result, many patients with such diseases – including those with health insurance – must rely on financial assistance from charitable foundations and drug manufacturers. Drug manufacturers' copay assistance programs play a crucial role in helping patients who rely on expensive medications meet those cost-sharing obligations and afford their medication throughout the year. These programs provide a true financial lifeline for many people living with chronic conditions.

However, insurance companies are increasingly undermining this assistance by not counting the amount of money covered by manufacturer copay assistance programs toward enrollees' annual deductibles and out-of-pocket limit. Instead, they keep the copay assistance funds used, and make enrollees keep paying. This little-known practice is called "copay accumulator adjustment policies" or "CAAPs." These policies contribute to insurance company profits while shifting the cost of expensive prescription drugs back to the patients who most rely on them, and the policies have become more common in recent years.

Unfortunately, the federal government has allowed copay accumulator adjustment policies to flourish, despite outcries from patients struggling to afford the prescription drugs they need to get and stay healthy. A rule finalized in the last year of the Trump administration allows health insurance companies to use copay accumulator adjustment policies at their discretion, even where there is no medically appropriate generic drug available. Despite President Biden's Executive Order directing the Department of Health and Human Services (HHS) to review policies that could pose barriers to health care, HHS has not yet reversed that decision.

Copay accumulator adjustment policies add extra costs for patients who have serious, complex, chronic illnesses, making it harder for these patients to afford the medicines they need. And the ongoing coronavirus pandemic has added yet another economic burden for millions of Americans. Many people still struggle to afford basic necessities like rent, gas, and groceries. Unexpected costs due to copay accumulator adjustment programs only increase this financial strain and jeopardize vulnerable patients' health at a time when people cannot afford to be sick.

This report examines how widely insurance companies have adopted these policies in the health insurance plans they offered to individuals and families in the health insurance marketplace for 2022. We found that companies continue to adopt these harmful policies, undermining access to essential and life-saving medicines for patients with health insurance.

This report covers:

- Overview of Our Methodology
- Findings
- How Copay Assistance Works with Copay Accumulator Adjustment Policies
- Cost-sharing and Plan Design Pose Barriers to Health Care
- The Impact of Copay Accumulator Adjustment Policies on Patients
- Federal Regulation and Legislation Regarding Copay Accumulator Adjustment Policies
- State Actions to Protect Patients' Access to Prescriptions
- Conclusion

Overview of Our Methodology

Copay accumulator adjustment policies can have an enormous impact on whether patients with HIV, AIDS, viral hepatitis, or other serious or chronic illnesses can afford their medicines. To find out how common these policies are and how they affect patients' insurance, The AIDS Institute conducted original research, reviewing individual market health plans across all states and the District of Columbia for 2022.[1] We did not review plans in the 12 states with laws that require insurance companies to count copay assistance toward enrollees' deductibles and out-of-pocket limits. We examined all available policy documents from all insurers that offered plans in the remaining states, looking for specific language regarding enrollee cost-sharing and copay accumulator policies. When those documents were ambiguous or unavailable, we called customer service lines to speak with insurance plan representatives.

Findings

Our review of health insurance plans offered to individuals and families through the ACA marketplaces for 2022 found that copay accumulator adjustment policies are widespread.

Our Review of health insurance plans offered to individuals and families through the ACA marketplaces for 2022 found that copay accumulator adjustment polices are widespread.

- In **35** states, there is **at least one plan** with a copay accumulator adjustment policy.
- In **eight** states, **every plan** includes a copay accumulator adjustment policy: Alabama, Alaska, Delaware, Idaho, Indiana, Iowa, Montana and South Carolina.
- In **30** states, **at least half** of all plans include a copay accumulator adjustment policy (Alabama, Alaska, California, Colorado, Delaware, Florida, Idaho, Indiana, Iowa, Kansas, Maine, Michigan, Minnesota, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Mexico, Ohio, Oregon, Rhode Island, South Carolina, South Dakota, Texas, Utah, Vermont, Washington, Wisconsin, Wyoming).[2]
- In **five** states, **one-third or fewer** plans have a copay accumulator policy: Massachusetts, Mississippi, New York, North Dakota and Pennsylvania.
- In only **three** states plus the District of Columbia, none of the plans include a copay accumulator adjustment policy: Hawaii, Maryland and New Jersey.
- In **12** states plus Puerto Rico, laws prohibiting copay accumulator policies in plans regulated by the states' departments of insurance will be in effect for 2022: Arkansas, Arizona, Connecticut, Georgia, Illinois, Kentucky, Louisiana, Oklahoma, North Carolina, Tennessee, West Virginia and Virginia. We did not review these states.

Despite allowing insurance companies to adopt copay accumulator policies, HHS did not require them to make information on these policies clear for patients shopping for coverage. Our research found that this information is difficult to locate and is often written in confusing language. People shopping for coverage may need to call specific insurers to learn about any copay accumulator adjustment policies if the information is not available in plan materials. However, customer service representatives do not always know their company's policy and cannot always answer accurately. In some cases, our researchers were unable to reach a representative at all, suggesting that people shopping for coverage may have the same problem.

- Overall, 36 plans in the states we researched did not share information about whether they had a copay accumulator policy in plan materials that were available to people before enrollment.[3] Of those, 16 plans do have a copay accumulator adjustment policy.[4]
- More plans included information about copay accumulator adjustment policies in their materials for 2022 plans than they did in their materials for 2021.

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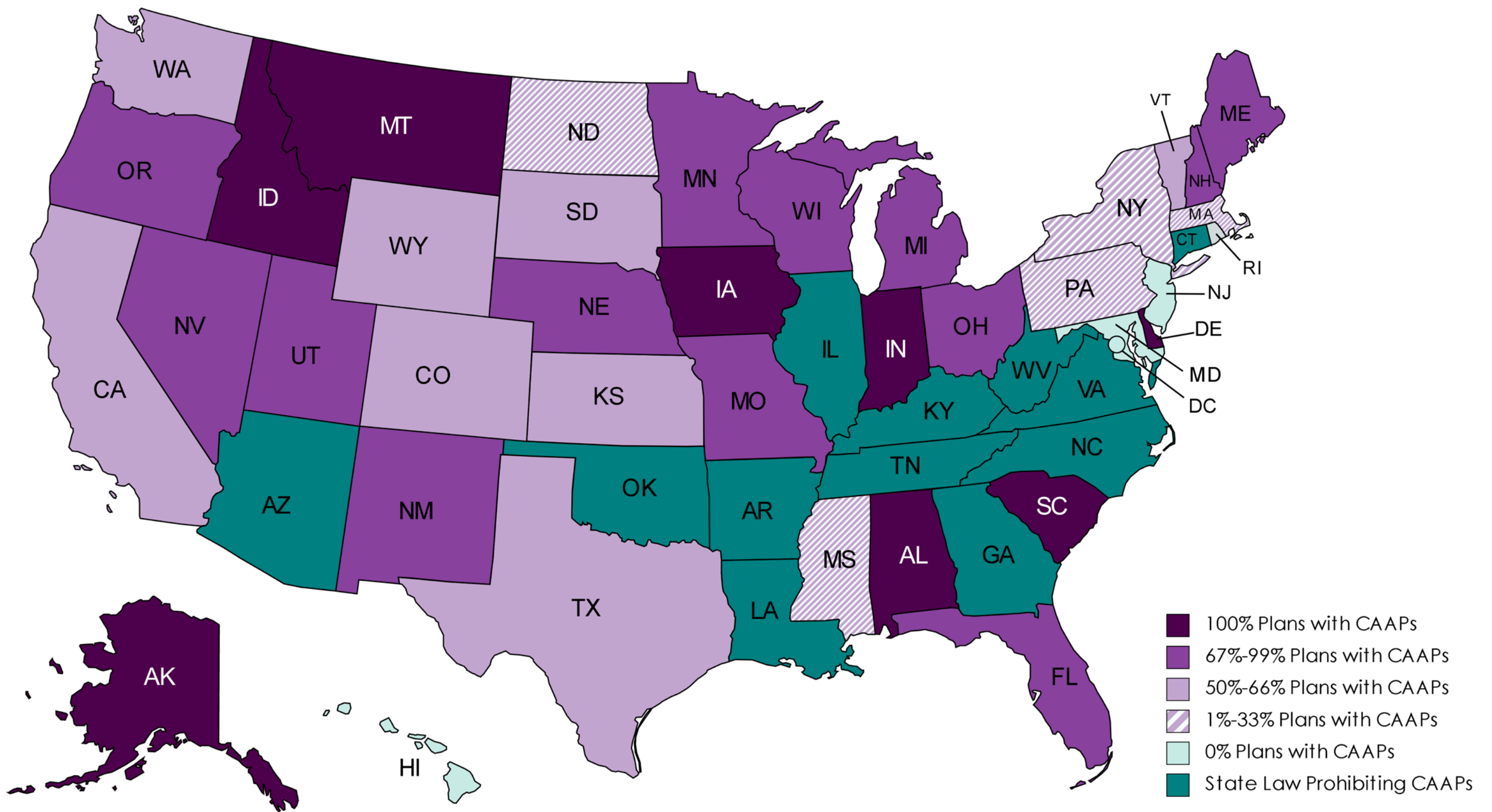
Percent of Plans in States with Copay Accumulator Policies



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How Copay Assistance Works with Copay Accumulator Adjustment Policies

When a patient who uses copay assistance has a health insurance plan with a copay accumulator adjustment policy, they may be confused when they have to pay the full cost of their medicines or their full deductible at the pharmacy counter several months into the plan year. At that point, they have spent their copay assistance and may have to pay their entire deductible (again) before they can get their prescription. Their pharmacy bill could run as high as several thousand dollars. Many patients cannot afford that and walk away empty-handed.

Copay accumulator adjustment policies put patients with chronic conditions in a tough position – forcing them to choose between their health and other financial obligations.

Example 1 is a simplified overview of how copay accumulator adjustment policies work for patients who use copay assistance.

Example 1

- Patient has a $1,000 deductible and $500 in copay assistance.

Without a Copay Accumulator Adjustment Policy

The $500 copay assistance *will* count toward the patient's deductible.

$1,000 - $500 = $500. The patient has to pay only the remaining $500 to reach their deductible.

With a Copay Accumulator Adjustment Policy

The $500 copay assistance *will not* count toward the patient's deductible.

$1,000 - $0 = $1,000. The patient has to pay the full $1,000 to reach their deductible.

Example 2 below provides more detail on how, several months into the plan year, a patient's deductible has not been reduced by the amount covered by their copay assistance. In Example 2, when the patient goes to the pharmacy in May, their copay assistance would be maxed out, and they would have to pay for the remainder of the drug's cost. The patient would continue

Copay accumulator adjustment policies put patients with chronic conditions in a tough position – forcing them to choose between their health and other financial obligations.

to pay the full price of the drug each month until they reach their deductible. At that point, they'd have to pay a percentage of the full drug price (as determined by their coinsurance).

The difference between the money an insurer would collect under the two examples will vary depending on the health plan's design and the plan's specific deductible, coinsurance or copayment, and annual out-of-pocket limit, as well as the cost of the prescription drug and copay assistance. However, the bottom line is consistent: The insurer makes more money when a copay accumulator adjustment policy is part of the health plan.[5]

Example 2

- Plan deductible: $4,600
- Annual out-of-pocket maximum: $8,550
- Cost-sharing for specialty tier prescription: 50% after deductible is met
- Monthly medication cost: $1,680
- Copay assistance total: $7,200

Scenario 1: Plan ***Without*** a Copay Accumulator Program

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total	Insurer collects
Copay Assistance	$1,680	$1,680	$1,240	$840	$840	$840	$80	$0	$0	$0	$0	$0	$7,200	
Remaining Deductible	$2,920	$1,240	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0		**$8,550**
Consumer Pays	$0	$0	$0	$0	$0	$0	$760	$590	$0	$0	$0	$0	$1,350	

Deductible is met **Copay assistance limit is met** **Out-of-Pocket maximum is met**

Scenario 2: Plan ***With*** a Copay Accumulator Program

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total	Insurer collects
Copay Assistance	$1,680	$1,680	$1,680	$1,680	$480	$0	$0	$0	$0	$0	$0	$0	$7,200	
Remaining Deductible	$4,600	$4,600	$4,600	$4,600	$3,400	$1,720	$40	$0	$0	$0	$0	$0		**$15,160**
Consumer Pays	$0	$0	$0	$0	$1,200	$1,680	$1,680	$40	$840	$840	$840	$840	$7,960	

Deductible is met **Copay assistance limit is met** **Out-of-Pocket maximum is met**

The insurer makes more money when a copay accumulator adjustment policy is part of the health plan.

Cost-Sharing and Plan Design Pose Barriers to Health Care

Health insurance has become more complicated in recent years, which makes it especially difficult for patients with high medical needs to choose a plan that meets those needs. Even very high-quality plans often include significant cost-shifting to patients who need expensive specialty medications, and the way plans shift those costs is not always clear to patients.

These insurance design issues and cost-sharing structure make it difficult for insured people who need health care to know how their insurance works and to afford the care they need.

Insurance Is (Still) Complicated

Many patients are unfamiliar with basic health insurance terms and concepts, such as the difference between a copayment and coinsurance. And most patients have never heard of copay accumulator adjustment policies. On top of that, insurers often describe these policies using complicated language that is buried deep in insurance plan documents. These factors make it difficult for patients who rely on specialty medications to identify which plans available to them include a copay accumulator adjustment policy, or to shop effectively for a plan that does not include such a policy.

Shifting More of the Burden to Patients

Over time, insurers have changed the structure of health insurance benefits to shift more costs to patients. For example, insurers have raised deductibles, added new prescription drug tiers and increased the use of coinsurance for higher tiers, and instituted “utilization management” measures.

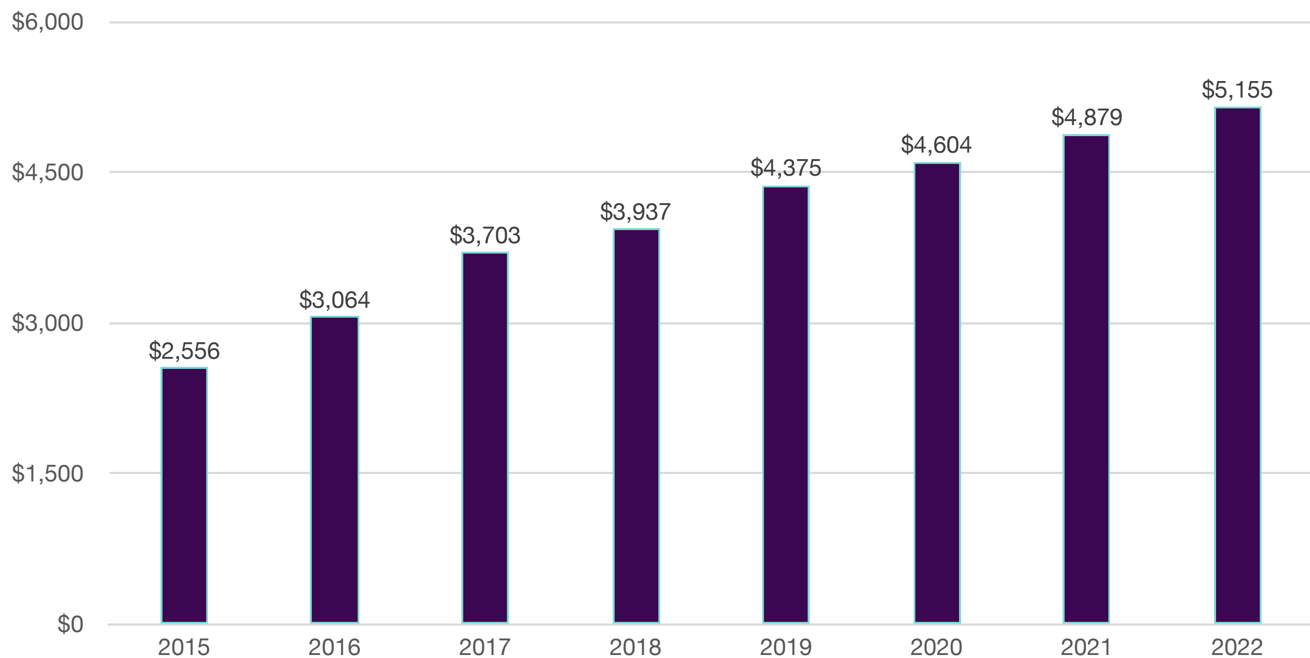
Deductibles

In 2022, the average deductible for the most popular level of health plans that offer mid-range coverage is $5,155, more than double the average deductible of $2,556 in 2015.[6,7] But many people may be enrolled in plans with even higher deductibles: In 2022, plans with the lowest premiums may have deductibles as high as the annual out-of-pocket limit for the year: $8,700 for an individual in 2022, and $9,100 for an individual in 2023.[8] While most enrollees will never hit an out-of-pocket limit of $9,100, people managing a chronic illness requiring specialty medications may be forced to pay this amount *every single year*, often in the first few months of the year.[9,10] Since most Americans do not have an extra $9,100 after they pay their health insurance premium, rent or

mortgage, food, transportation, childcare, and other basic needs, copay assistance is often the only way they can afford the medication they need, even if they have insurance.[11]

Example 3 shows how deductibles have more than doubled since 2015.

Example 3



Source: The AIDS Institute analysis of CMS public use file data and Kaiser Family Foundation reports

Since most Americans do not have an extra $9,100 after they pay their health insurance premium, rent or mortgage, food, transportation, childcare, and other basic needs, copay assistance is often the only way they can afford the medication they need, even if they have insurance.

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Prescription Drug Tiers That Use Coinsurance

More plans now have four or more prescription drug formulary tiers. In 2019, 84% of silver plans in the marketplace (the most popular plans) used a specialty drug tier.[12] Health insurers place many of the drugs used to treat complex diseases such as HIV, hemophilia, arthritis and epilepsy in the highest or specialty tiers. Higher formulary tiers often use coinsurance (a percentage of the drug's list price) rather than copayments (a fixed dollar amount). And since these tiers have higher cost-sharing, plans with more tiers require patients to pay more out of pocket.[13]

It is very common for insurers to charge coinsurance of 30-50% for higher tiers. One group of researchers found that the vast majority (81%) of silver level individual market plans required enrollees to pay coinsurance for specialty drugs, and just 12% cover any specialty drugs before the deductible is met.[14] The median coinsurance amount for the 69% of silver plans using coinsurance post-deductible was 40%. That 40% could translate to thousands of dollars a month for a patient with a chronic condition. And because coinsurance is based on the list price rather than the discounted price the insurer pays for prescription drugs, patients are paying significantly more of the cost of their medication than the coinsurance percentage might indicate.

Utilization Management

Insurers do not rely just on cost to deter patients from expensive treatments. Insurance plans also employ "utilization management tools," such as step therapy, generic substitution, prior authorization, and pill quantity limits. These techniques enable the insurer to steer patients toward less expensive therapies whenever possible. Patients who are ultimately prescribed more expensive treatments have exhausted all other options, gaining access to them because less expensive options did not work or were not medically appropriate for them. Copay assistance offers a lifeline to these patients to help them afford the steep cost-sharing charged for these treatments.

The Impact of Copay Accumulator Adjustment Policies on Patients

High Out-of-Pocket Costs Prevent Patients From Taking Their Medications

For many diseases, like HIV and hepatitis C, there are no generic alternatives to brand-name medications. In addition, even when generics

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are available, they are still often prohibitively expensive and unaffordable for patients. For example, a generic drug that came on the market in 2018 to treat multiple sclerosis (MS) was priced 20% lower than the brand-name drug – at approximately $60,000 a year.[15]

High monthly costs make it more likely that patients will stop taking their medications, which could seriously worsen their health over the long term. One survey found that among people who said they did not take their medication as prescribed due to cost, 20% did not fill a prescription, and another 12% skipped doses or cut pills in half to extend their supply.[16]

Not following a prescribed treatment regimen for a complicated health condition can lead to dangerous health consequences, such as irreversible worsening of their disease, hospitalization or becoming resistant to the drug. Another patient experience survey revealed that of the individuals who experienced an interruption to their prescription drug adherence, 82% of patients with infectious diseases like HIV reported negative health outcomes.[17]

Even delaying treatment temporarily can have a dramatic impact on a patient's long-term health and end up costing the health care system more in emergency room visits or additional medical treatment. And during the ongoing coronavirus pandemic, hospitals across the nation have, at times, been unable to ensure that they can provide care for non-COVID patients who need hospitalization.[18]

How much does a patient have to pay for their medicine before they opt to leave their prescription at the counter? That amount is relatively low. Recent research on medication adherence found that when out-of-pocket costs reach $75-$125, more than 40% of patients leave their prescriptions at the counter. When those costs hit $250, over 70% of patients leave empty-handed.[19]

Copay assistance ensures that patients with expensive, chronic conditions can afford their medicines even with the growing out-of-pocket costs that insurers require. Copay accumulator adjustment policies remove that safety net.

Copay Accumulator Adjustment Policies Can Also Harm People with Employer-Sponsored Insurance

While The AIDS Institute focused on insurers in the individual market because information on their health plan policies is more accessible, copay accumulator adjustment policies are also prevalent in employer-sponsored health plans. Almost half (49.6%) of Americans

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who have health insurance are covered by employer-sponsored health insurance.[20] Therefore, decisions made by employers about pharmacy benefit design have the potential to affect a much greater number of people.

With employers concerned about rising health care expenditures, they have increasingly turned to cost control mechanisms. A 2019 survey of a sample of large employers found that 34% were already using copay accumulator adjustment policies, and an additional 4% sought to add them in the next year – a significant increase over previous years.[21] The three largest pharmacy benefit managers (PBMs) are now marketing copay accumulator adjustment policies to employers that are designing their insurance plans,[22] which may be contributing to their increasing prevalence. However, the decision of how to balance reduced costs and employees' health is ultimately up to employers.

An additional reason to be concerned about copay accumulator adjustment policies in employer-sponsored health insurance plans is that most of the large plans do not have to follow state insurance laws. Therefore, even in states that have banned copay accumulator programs, a significant number of residents may still be enrolled in health insurance plans that have such programs.[23]

It will take federal regulatory or legislative action to truly protect people from copay accumulator programs.

Health Insurers Profit from Using Copay Accumulator Adjustment Policies

One argument that health insurers use to justify copay accumulator adjustment policies is that copay assistance leads patients to use higher-cost drugs, which then drives up drug prices. However, research shows that the use of copay assistance does not affect overall drug prices and does not steer patients toward more expensive drugs.[24]

Instead, this assistance helps patients afford the medications they've been prescribed. Furthermore, copay assistance makes up a tiny sliver of overall pharmaceutical claims. One group of researchers who studied the issue concluded that of all the commercial market[25] prescription purchases between 2013 and 2017, only 3.4% were bought using copay assistance, and only 0.4% of those prescription drugs had a generic equivalent.[26]

Another factor that affects whether health insurers use copay accumulator programs is that they gain financially by their use. Example 2 on p. 8 shows how payments for a prescription

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drug would work over the course of a plan year for a plan with a copay accumulator adjustment policy and a plan without one. The example shows that when a plan has such a policy, the insurer collects significantly more money for the same medicine than it would without the policy. That additional money comes from the amount covered by the copay assistance even though those funds were intended to go to patients. This can force patients to pay again the amount they received in cost-sharing assistance.

Clearly, insurers have taken advantage of the liberties granted by the federal government through recent regulations to line their pockets at the expense of patients.

Federal Regulation and Legislation Regarding Copay Accumulator Adjustment Policies

The federal government has taken multiple positions on copay accumulator adjustment policies over the past few years in its annual "Notice of Benefit and Payment Parameters," (NBPP) which governs all private health insurance subject to the Affordable Care Act.[27]

The 2020 rule significantly restricted the ability of insurers to use copay accumulator adjustment policies except in very limited circumstances, allowing the practice only for specialty drugs that have a medically-appropriate generic equivalent.[28] While a broad ban on all copay accumulator adjustment policies would have provided the best patient protection, this final rule was still a significant win for patients and patient advocates.

However, before the rule went into effect, HHS announced that it would delay enforcement until 2021.[29] The final 2021 Notice of Benefit and Payment Parameters officially reversed HHS' original stance on patient copay assistance: The notice permitted insurers to use copay accumulator adjustment policies whenever they want without restrictions.[30] Furthermore, the final rule removed the protection for copay assistance in cases where no medically appropriate generic drug is available. This was a devastating blow to patient access and put those who rely on specialty medications in a precarious position.

HHS' rationale for reversing course on copay accumulator adjustment policies is complicated. It defers to the IRS, which contends that the rule conflicted with an IRS policy prohibiting the use of pharmacy coupons or discounts for people who have a Health Savings Account (HSA) paired with a high-deductible health plan.[31] That IRS policy says that people who have an HSA must pay the full amount of their health care without discounts until they meet the

minimum deductible for such a plan ($1,400 for an individual, $2,800 for a family).[32] In order to accommodate the IRS' concern, HHS opted to remove the restriction on use of copay accumulator adjustment policies altogether, rather than modify it to ensure that copay assistance is counted toward any deductible after the first $1,400 is met for enrollees who contribute to an HSA.

The failure of HHS to regulate insurers' use of copay accumulator adjustment policies prompted congressional leaders to introduce legislation that requires health plans to count the value of copay assistance toward patient cost-sharing requirements. Representatives Donald McEachin (D-VA) and Rodney Davis (R-IL) introduced bipartisan legislation in November 2021, entitled the "Help Ensure Lower Patient Copays Act," HR 5801. If enacted, this legislation would prohibit the use of copay accumulator adjustment policies in individual and employer health plans.

State Actions to Protect Patient Access to Prescriptions

While the federal government has not prohibited copay accumulator adjustment policies, HHS' 2021 Notice of Benefit and Payment Parameters allowed states to do so. The growing number of copay accumulator programs, combined with the lack of federal patient protections, has motivated more states to act. To date, 12 states have adopted laws requiring insurance plans and pharmacy benefit managers (PBMs) to count the value of copay assistance toward an enrollee's annual deductible and out-of-pocket limit.

- To date, six states and one U.S. territory have enacted laws requiring insurers to count all copayments made by or on behalf of enrollees toward their annual deductibles and out-of-pocket limits: Connecticut, Illinois, Louisiana, Oklahoma, Virginia, West Virginia and Puerto Rico.
- Six more states enacted laws that prohibit copay accumulator adjustment policies for prescription drugs when no generic alternative is available but allow insurers to exclude copay assistance for a brand-name drug when a generic is available: Arizona, Arkansas, Georgia, Kentucky, North Carolina and Tennessee.

As state legislatures look ahead to their 2022 sessions, several states have already begun to build on the work started in prior sessions. And many additional states are prioritizing copay assistance bills. States where patient advocates are building grassroots support and working with key legislators for 2022

include Colorado, Florida, Indiana, Maryland, Mississippi, Ohio, Oregon, Pennsylvania, Rhode Island, South Dakota and Texas.

Conclusion

At the most basic level, copay accumulator adjustment policies discriminate against people living with chronic illness, interrupting their access to needed treatment and threatening their health. The federal government and state governments should take action to address this problem and help patients.

Endnotes

1 The individual market is the health insurance market for coverage that is available to people who do not get health coverage through their employer or a government program. It is bought directly from an insurer.

2 States in which at least 66% of insurance plans have copay accumulator policies include Alabama, Colorado, Connecticut, Delaware, Florida, Hawaii, Idaho, Indiana, Iowa, Kentucky, Louisiana, Maine, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nevada, New Hampshire, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, South Carolina, Tennessee, Texas, Washington and Wisconsin.

3 Information on copay accumulator policies was gathered by calling each insurer's customer service line.

4 BCBS, Alabama; Western Health Advantage, California; Highmark, Delaware; Capital Health Plan, Florida; US Health & Life, Indiana, Kansas, Michigan; BCBS of Kansas; Community Health Options, Maine; Fallon Community Health Plan, Massachusetts; Aetna, Missouri; Health Plus, New York; Geisinger Health Plan, Pennsylvania; Avera, South Dakota; MVP, Vermont; Community Health Network, Washington; WPS, Wisconsin.

5 Prescription Costs, Health Plan Design, and Copay Assistance Tables: These scenarios also do not take into account the discount that the insurer receives through negotiations with the drug's manufacturer. This discount — in the form of a rebate – adds to the insurer's net gains, since those savings are not passed on to patients.

6 Katie Keith, "Premiums Drop Slightly as 2021 Open Enrollment Period Draws Near," *Health Affairs Blog,* October 23, 2020, https://www.healthaffairs.org/do/10.1377/hblog20201023.33540/full/#:~:text=At%20the%20same%20time%2C%20deductibles,rose%20from%20%241%2C432%20to%20%241%2C533.

7 "Plans with More Restrictive Networks Comprise 73% of Exchange Market," Avalere, November 20, 2017, https://avalere.com/press-releases/plans-with-more-restrictive-networks-comprise-73-of-exchange-market.

8 The Affordable Care Act limits the amount that people must pay for health care every year with an "annual out-of-pocket limit." That limit is $8,700 in 2022 and is scheduled to increase to $9,100 in 2023.

9 Center for Consumer Information and Insurance Oversight, *Affordability in the Marketplace Remains an Issue for Moderate Income Americans.* (January 2021). https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Impact-Premium-Affordability.pdf.

10 K. Hempstead. *Marketplace Pulse: Cost-Sharing in the Marketplace, 2021*. Robert Wood Johnson Foundation, (June 28, 2021), https://www.rwjf.org/en/library/research/2021/06/marketplace-pulse-cost-sharing-in-the-marketplace-2021.html.

11 Board of Governors of the Federal Reserve System, *Report on the Economic Well-Being of US Households in 2019-May 2020*. https://www.federalreserve.gov/publications/2020-economic-well-being-of-us-households-in-2019-overall-economic-well-being-in-2019.htm.

12 K. Hempstead, *Marketplace Pulse: Cost-Sharing for Drugs Rises Sharply at Higher Tiers* (Robert Wood Johnson Foundation, March 1 2019), https://www.rwjf.org/en/library/research/2019/03/cost-sharing-for-drugs-rises-sharply-at-higher-tiers.html.

13 Cost-sharing is the portion of costs the enrollee pays out of pocket for insurance, such as deductibles, copayments, or coinsurance. This does not include premiums.

14 K. Hempstead, *Marketplace Pulse: Cost-Sharing for Drugs Rises Sharply at Higher Tiers*.

15 Charlotte Huff, "MS Drugs: Expensive, Often Lifelong, and Not Cost Effective," Managed Care Mag.com, September 30, 2018, https://www.managedcaremag.com/archives/2018/10/ms-drugs-expensive-often-lifelong-and-not-cost-effective.

16 Ashley Kirzinger, Lunna Lopes, Brian Wu, and Mollyann Brodie, *KFF Health Tracking Poll -February 2019 Prescription Drugs* (Kaiser Family Foundation, March 1, 2019), https://www.kff.org/health-costs/poll-finding/kff-health-tracking-poll-february-2019-prescription-drugs/.

17 PhRMA, *Patient Experience Survey: Barriers to Health Care Access in the Patient Experience* (PhRMA, December 2021), https://phrma.org/-/media/Project/PhRMA/PhRMA-Org/PhRMA-Org/PDF/P-R/PES-Report_100621_Final.pdf.

18 Centers for Disease Control and Prevention, "Impact of Hospital Strain on Excess Deaths During the COVID-19 Pandemic — United States, July 2020–July 2021," *Morbidity and Mortality Report* 70, no 46 (November 19, 2021): 1613–1616, https://www.cdc.gov/mmwr/volumes/70/wr/mm7046a5.htm.

19 IQVIA, *Medicine Use and Spending in the U.S.: A Review of 2019 and Outlook to 2023* (IQVIA, May 2019), https://www.iqvia.com/insights/the-iqvia-institute/reports/medicine-use-and-spending-in-the-us-a-review-of-2018-and-outlook-to-2023.

20 Kaiser Family Foundation, "Health Insurance Coverage of the Total Population," 2020, https://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

21 Kelsey Waddill, "Employers Focus on High-Cost Claims, Drug Spending into 2020," Xtelligent Healthcare Media, August 15, 2019, https://healthpayerintelligence.com/news/employers-focus-on-high-cost-claims-drug-spending-into-2020.

22 Aimed Alliance, "An Update on Copay Accumulator Policies," 2019, https://aimedalliance.org/an-update-on-copay-accumulator-policies/.

23 Aimed Alliance, "An Update on Copay Accumulator Policies."

24 IQVIA, *Medicine Use and Spending in the U.S*.

25 The commercial market refers to health insurance that is not provided by a government program. It includes employer-sponsored insurance and insurance that people buy through the ACA's health insurance marketplaces.

26 IQVIA, *An Evaluation of Co-Pay Card Utilization in Brands After Generic Competitor Launch* (IQVIA, January 2018), https://www.iqvia.com/locations/united-states/library/fact-sheets/evaluation-of-co-pay-card-utilization.

27 Department of Health and Human Services, "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2020," The NBPP is issued every spring, carrying the date of the following calendar year (the 2020 NBPP was issued in April 2019).

28 The Notice of Benefit and Payment Parameters permitted exclusions where a generic equivalent is available and medically appropriate, but it also allowed for an exceptions and appeals process for patients who need the brand-name version of a drug.

29 Department of Health and Human Services, *FAQs About Affordable Care Act Implementation Part 40* (HHS, August 26, 2019), https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQs-Part-40.pdf.

30 Department of Health and Human Services, "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2021," *Federal Register*, February 2, 2020, https://www.federalregister.gov/documents/2020/02/06/2020-02021/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2021.

31 IRS, *Health Savings Accounts – Additional Qs & As. Notice 2004-50*, (IRS, August 9, 2004), https://www.irs.gov/pub/irs-drop/n-04-50.pdf.

32 Note that not all health plans with high deductibles may be paired with an HSA. The IRS defines a high-deductible health plan (HDHP) as a plan that has a deductible of between $1,400 and $7,050 for a plan that covers one person. In the individual market, many plans have deductibles higher than $7,050 and thus cannot be used with an HSA. Although not technically an HDHP by IRS standards, most people consider a plan with a deductible of between $7,050 and $8,700 (the maximum deductible for an ACA-qualified health plan in 2022) to be a high deductible plan.

Appendices

Federal Regulation and Legislation Timeline

Timeline	Summary	Policy Vehicle
April 2019	The 2020 Notice of Benefit & Payment Parameters (NBPP) finalized in April 2019, included a provision that stated health plans must count manufacturer copay assistance toward the beneficiary's deductible and out-of-pocket costs for a brand drug where no generic equivalent is available. The provision also outlined the requirement to count manufacturer assistance for generic prescriptions through an appeals process.	2020 NBPP
August 2019	In August 2019, HHS with the Dept of Labor and Treasury Dept issued and FAQ about the ACA Implementation. This announced CCIIO's decision to delay enforcement of the copay accumulator provision of the 2020 NBPP, citing a possible conflict with a 2004 IRS rule related to high deductible health plans.	Tri-Agency FAQ
May 2020	The 2021 NBPP finalized in May 2020 reversed HHS' official policy on copay accumulators, leaving it to the discretion of health plans whether or not to count manufacturer copay assistance toward a beneficiary's cost-sharing responsibilities.	2021 NBPP
July 2020	Legislation was introduced in July 2020 in the House that would delay the implementation of the 2021 NBPP due to COVID-19.	HR 7647
November 2021	Legislation introduced in November 2021 by Representatives McEachin and R. Davis that will require copay assistance to be counted toward out-of-pocket cost-sharing requirements, and close a loophole that permits insurers to deem certain drugs "non-essential," for which no cost sharing paid will count toward the deductible or out-of-pocket maximum.	HR 5801

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State Legislation Passed

State	Copay Accumulator Language	Source / Date Signed into Law
West Virginia	When calculating an insured's contribution to any applicable cost sharing requirement, including, but not limited to, the annual limitation on cost sharing subject to 42 U.S.C. §18022(c) and 42 U.S.C. § 300gg-6(b): (1) An insurer shall include any cost sharing amounts paid by the insured or on behalf of the insured by another person; and (2) A pharmacy benefits manger shall include any cost sharing amounts paid by the insured or on behalf of the insured by another person.	West Virginia HB2770 3/9/2019
Virginia	When calculating an enrollee's overall contribution to any out-of-pocket maximum, deductible, copayment, coinsurance, or other cost-sharing requirement under a health plan, a carrier shall include any amounts paid by the enrollee or paid on behalf of the enrollee by another person.	Virginia SB1596 3/21/2019
Arizona	This law requires that financial assistance from outside parties, including drug manufacturers, count towards an enrollee's total out-of-pocket maximum when there is no generic version of their prescription medication available, or when the patient has received permission to take the name brand drug through prior authorization, step therapy, or an issuer's appeals process.	Arizona HB2166 4/11/2019
Illinois	A health care plan shall apply any third-party payments, financial assistance, discount, product vouchers, or any other reduction in out-of-pocket expenses made by or on behalf of such insured for prescription drugs toward a covered individual's deductible, copay, or cost-sharing responsibility, or out-of-pocket maximum associated with the individual's health insurance.	Illinois HB0465 8/23/2019
Georgia	When calculating an insured's contribution to any out-of-pocket maximum, deductible, or copayment responsibility, a pharmacy benefits manager shall include any amount paid by the insured or paid on his or her behalf through a third-party payment, financial assistance, discount, or product voucher for a prescription drug that does not have a generic equivalent or that has a generic equivalent but was obtained through prior authorization, a step therapy protocol, or the insurer's exceptions and appeals process.	Georgia SB313 8/5/2020
Kentucky	To the extent permitted under federal law, an insurer issuing or renewing a health plan on or after the effective date of this Act, or a pharmacy benefit manager, shall not: (a) Require an insured purchasing a prescription drug to pay a cost-sharing amount greater than the amount the insured would pay for the drug if he or she were to purchase the drug without coverage. (already in statue prior to SB 45) (b) Exclude any cost-sharing amounts paid by an insured or on behalf of an insured by another person for a prescription drug, including any amount paid under paragraph (a) of this subsection, when calculating an insured's contribution to any applicable cost-sharing requirement. The requirements of this paragraph shall not apply in the case of a prescription drug for which there is a generic alternative, unless the insured has obtained access to the brand prescription drug through prior authorization, a step therapy protocol, or the insurer's exceptions and appeals process.	Kentucky SB45 3/25/2021

State	Provision	Bill / Date
Oklahoma	Any of the following acts by an insurer, if committed in violation of Section 1250.3 of this title, constitutes an unfair claim settlement practice exclusive of paragraph 16 of this section which shall be applicable solely to health benefit plans: 18. As a health insurer that provides pharmacy benefits or a pharmacy benefits manager that administers pharmacy benefits for a health plan, failing to include any amount paid by an enrollee or on behalf of an enrollee by another person when calculating the enrollee's total contribution to an out-of-pocket maximum, deductible, copayment, coinsurance or other cost-sharing requirement.	Oklahoma HB2678 4/19/2021
Arkansas	(b)(1) When calculating an enrollee's contribution to any applicable cost-sharing requirement, a healthcare insurer shall include any cost-sharing amounts paid by the enrollee or on behalf of the enrollee by another person. (2) The cost-sharing requirement under subdivision (b)(1) of this section does not apply for cost-sharing of a prescription drug if a name-brand prescription drug is prescribed and the prescribed drug: (A) Is not considered to be medically necessary by the prescriber; and (B) Has a medically appropriate generic prescription drug equivalent.	Arkansas HB1569 4/27/2021
Tennessee	(a) When calculating an enrollee's contribution to an applicable cost sharing requirement, an insurer shall include cost sharing amounts paid by the enrollee or on behalf of the enrollee by another person. (b) Subsection (a) does not apply to a prescription drug for which there is a generic alternative, unless the enrollee has obtained access to the brand name prescription drug through prior authorization, a step therapy protocol, the insurer's exceptions and appeals process, or as specified in § 53-10-204(a).	Tennessee HB619 5/12/2021
Connecticut	Sec 4) and 5) When calculating an enrollee's liability for a coinsurance, copayment, deductible or other out-of-pocket expense for a covered benefit, give credit for any discount provided or payment made by a third party for the amount of, or any portion of the amount of, the coinsurance, copayment, deductible or other out-of-pocket expense for the covered benefit.	Connecticut SB1003 6/2/2021
Louisiana	B. When calculating an enrollee's contribution to any applicable 30 cost-sharing requirement, a health insurance issuer shall include any cost-sharing amounts paid by the enrollee or on behalf of the enrollee by another person.	Louisiana SB94 6/21/2021
North Carolina	(c1) When calculating an insured's contribution to any out-of-pocket maximum, deductible, copayment, coinsurance, or other applicable cost-sharing requirement, the insurer or pharmacy benefits manager shall include any amounts paid by the insured, or on the insured's behalf, for a prescription that is either: (1) Without an AB-rated generic equivalent. (2) With an AB-rated generic equivalent if the insured has obtained authorization for the drug through any of the following: a. Prior authorization from the insurer or pharmacy benefits manager. b. A step therapy protocol. c. The exception or appeal process of the insurer or pharmacy benefits manager.	North Carolina SB257 9/20/2021

Puerto Rico	Any health insurance organization or insurer that provides prescription drug benefits, a pharmacy provider or benefits manager shall include in the calculation or requirement of cost sharing or out-of-pocket maximum, any payment, discount, or item that is part of a financial assistance program, discount plan, coupon, or any contribution offered to the insured by the manufacturer. These items shall be considered for the sole benefit of the patient in the calculation of his contribution, out-of-pocket expenses, copayments, co-insurance, deductible or in compliance with shared contribution requirements. These contributions, discounts, coupons will be available and may be used at all health care provider, in accordance with program requirements, regardless of where the discount or coupon is acquired. The use of the benefit accumulator, maximizer, or any other similar program that has the effect of implementing a restriction on liability set forth in this subparagraph is prohibited.	Puerto Rico S.1658
NCOIL Model Language	When calculating an enrollee's overall contribution to any out-of-pocket maximum or any cost-sharing requirement under a health plan, a [Carrier/Insurer/Issuer] or pharmacy benefit manager shall include any amounts paid by the enrollee or paid on behalf of the enrollee by another person.	Introduced to NCOIL and under considering in 2021

2022 Copay Accumulator Data Collection Appendix

State	Issuer	2022 CAAP
Alabama	BCBS	Yes
	Bright Health	Yes
	United Healthcare	Yes
Alaska	Premera (BCBS)	Yes
	Moda	Yes
Arizona	State law	
Arkansas	State law	
California	Anthem	Yes
	BlueShield	Yes
	Health Net	Yes
	Molina	Yes
	Oscar	Yes
	Western Health Advantage	Yes
	CCHP	No
	LA Care Health Plan	No
	Sharp Health	No
	Valley Health Plan	No
	Kaiser Permanente	No*
Colorado	Anthem	Yes
	Bright Health	Yes
	Rocky Mountain	Yes
	Oscar	Yes
	Cigna	No
	Denver Health Medical Plan	No
	Friday Health	No
	Kaiser	No*
Connecticut	State Law	
D.C.	Kaiser Permanente	No*
	CareFirst Blue Choice HMO	No*
	CareFirst PP0	No*
Delaware	Highmark	Yes

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State	Issuer	2022 CAAP
Florida	Ambetter	Yes
	AvMed	Yes
	Bright Health	Yes
	Florida Blue	Yes
	Florida Health Care Plan	Yes
	Health First	Yes
	Florida Blue HMO (BCBS)	Yes
	Capital Health Plan	Yes
	Coventry (AetnaCVS)	Yes
	Sunshine State	Yes
	United HealthCare	Yes
	Cigna	No*
	Molina	No*
	Oscar	No*
Georgia	**State law**	
Hawaii	HMSA	No
	Kaiser	No*
Idaho	Blue Cross	Yes
	Mountain Health CO-OP	Yes
	SelectHealth	Yes
	PacificSource	Yes
	Regence BS	Yes
Illinois	**State law**	
Indiana	Celtics Insurane Co. (Ambetter)	Yes
	CareSource	Yes
	Anthem	Yes
	US Health&Life (Ascension)	Yes
Iowa	Medica	Yes
	Wellmark Health Plan	Yes
	Oscar	Yes

State	Issuer	2022 CAAP
Kansas	Ambetter from Sunflower Health (Centene)	Yes
	BCBS of Kansas City	Yes
	Medica	Yes
	US Health&Life (Ascension)	Yes
	BCBS of Kansas	No
	Cigna	No
	Oscar	No
Kentucky	**State law**	
Louisiana	**State law**	
Maine	Anthem	Yes
	Community Health Options	Yes
	Harvard Pilgrim	No
Maryland	UnitedHealthcare	No
	CareFirst BCBS	No
	CareFirst Blue Choice	No
	Kaiser	No*
Massachusetts	United Healthcare	Yes
	Fallon Community Health Plan	Yes
	BCBS	No
	Boston Medical Center HealthNet	No
	Harvard Pilgrim Health Care	No
	Health New England	No
	Tufts Health Public Plans	No
	Tufts HMO	No
	AllWays Health Partners	No*
Michigan	Blue Care Network	Yes
	BCBS	Yes
	McLaren Health	Yes
	Oscar Health	Yes
	Physicians Health Plan	Yes
	United Healthcare	Yes
	US Health&Life (Ascension)	Yes
	Total Health Care USA/Priority	No
	Meridian	No*
	Molina	No*

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State	Issuer	2022 CAAP
Minnesota	Group Health/Health Partners	Yes
	Medica	Yes
	PreferredOne	Yes
	Quartz	Yes
	UCare	Yes
	Blue Plus	No
Mississippi	Ambetter/Magnolia	Yes
	Cigna	No
	Molina	No*
Missouri	Aetna	Yes
	Ambetter/Celtic (Centene)	Yes
	Anthem	Yes
	Blue KC	Yes
	Cox	Yes
	Medica	Yes
	Oscar	Yes
	SSM/WellFirst	Yes
	Cigna	No
Montana	BCBS	Yes
	Montana Health CO-OP	Yes
	PacificSource	Yes
Nebraska	Medica	Yes
	Oscar	Yes
	Bright Health	No*
Nevada	Aetna	Yes
	Health Plan of NV	Yes
	Hometown Health	Yes
	HMO Nevada (HMO Colorado/Anthem)	Yes
	SelectHealth	Yes
	SilverSummit	Yes
	Friday	No
New Hampshire	Ambetter/Celtic	Yes
	Anthem	Yes
	Harvard Pilgrim	No

State	Issuer	2022 CAAP
New Jersey	Oscar	No
	AmeriHealth	No
	Horizon Healthcare Services (BCBS)	No
New Mexico	BCBS	Yes
	Molina	Yes
	Presbyterian Health Plan	Yes
	True Health	Yes
	Western Sky Community Care (Ambetter/Centene)	Yes
	Friday	No
New York	Health Plus HP	Yes
	Capital District Physicians' Health Plan	No
	Emblem	No
	Excellus Health	No
	Fidelis	No
	Healthfirst PHSP	No
	HealthNow New York (BCBS of Western NY; Blue Cross of NE NY)	No
	Independent Health Benefit Corporation	No
	MVP Health Plan	No
	Oscar	No
	UnitedHealthcare of NY	No
	Univera Healthcare	No
	Metro Plus Health Plan	Unable to confirm
North Carolina	**State law**	
North Dakota	Medica	Yes
	BCBS	No
	Sanford	No

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State	Issuer	2022 CAAP
Ohio	Aultcare	Yes
	Ambetter	Yes
	BCBS	Yes
	CareSource	Yes
	Medical Mutual	Yes
	Molina	Yes
	Oscar Buckeye State Insurance Corp	Yes
	Oscar Insurance Corp. of Ohio	Yes
	Paramount	Yes
	Summa	No
Oklahoma	**State law**	
Oregon	BridgeSpan	Yes
	Moda	Yes
	PacificSource	Yes
	Regence	Yes
	Kaiser	No
	Providence	No
Pennsylvania	Geisinger Health Plan	Yes
	Geisinger Quality Options	Yes
	Oscar Health	Yes
	PA Health and Wellness (Ambetter)	Yes
	Capital Advantage Assurance	No
	Cigna	No
	Highmark Benefits Group	No
	Highmark Coverage Advantage	No
	Highmark, Inc.	No
	Keystone Health Plan East (Independence Blue Cross HMO)	No
	QCC Insurance Company (Independence Blue Cross PPO)	No
	UPMC Health Coverage	No
	UPMC Health Options	No
Rhode Island	BCBS	Yes
	Neighborhood Health Plan of RI	No

State	Issuer	2022 CAAP
South Carolina	BCBS	Yes
	Ambetter/Absolute Total Care	Yes
	Bright	Yes
	Molina	Yes
South Dakota	Avera	Yes
	Sanford	No
Tennessee	State law	
Texas	Aetna/CVS	Yes
	BCBS	Yes
	Celtic/Ambetter	Yes
	CHRISTUS	Yes
	Community Health Choice	Yes
	Molina	Yes
	Oscar	Yes
	United Healthcare	Yes
	Bright Healthcare	No
	Friday	No
	Scott & White	No
	Sendero	No
	SHA/FirstCare (acquired by Scott & White)	No
Utah	BridgeSpan	Yes
	Bright Health	Yes
	Molina	Yes
	Regence	Yes
	SelectHealth	Yes
	University of Utah Health Plans	Yes
	Cigna	No
Vermont	MVP	Yes
	BCBS of VT	No
Virginia	State law	

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State	Issuer	2022 CAAP
Washington	BridgeSpan Health Company	Yes
	Community Health Network of WA	Yes
	Coordinated Care Corporation	Yes
	PacificSource Health Plans	Yes
	Premera Blue Cross	Yes
	Regence BCBS	Yes
	Regence BS	Yes
	United Healthcare	Yes
	Kaiser Foundation Health Plan of the NW	No
	Kaiser Foundation Health Plan of Washington	No
	LifeWise Health Plan of Washington	No
	Molina Healthcare of Washington	No*
West Virginia	**State law**	
Wisconsin	Anthem BCBS	Yes
	Aspirus Health Plan	Yes
	Children's Community Health Plan	Yes
	Common Ground Healthcare Cooperative	Yes
	Dean Health Plan	Yes
	HealthPartners	Yes
	Medica Health Plans of WI	Yes
	MercyCare HMO	Yes
	Molina	Yes
	Security Health Plan of Wisconsin	Yes
	WPS (Arise Health Plan)	Yes
	Network Health	No
	Quartz Health Benefits	No
	Group Health Cooperative of South Central WI	No*
Wyoming	Mountain Health CO-OP	Yes
	BCBS	No

*Plan applies copay assistance for brand drug with no generic equivalent to patient's deductible and out-of-pocket cost.

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