ALL COPAYS COUNT COALITION

Correcting the Record on Copay Assistance and Accumulator Adjustment Policies

MYTH

Copay assistance provided by pharmaceutical manufacturers keeps drug prices high, by incentivizing the use of high-cost treatments instead of lower cost generic equivalents.

FACT

Copay accumulator adjustment policies (CAAPs) largely target specialty medications for which there are generally no generic equivalents available. In fact, data shows that for all commercial market claims for specialty medications where copay assistance was used, only 3.4% of those claims were for a product that may have a generic alternative available.[1] If copay assistance programs were intended to drive patients away from generic alternatives, then this share would be significantly higher.

The truth is that copay assistance is a critical lifeline that helps ensure the most vulnerable patients can access their needed medications. When barriers prevent patients from accessing these medications, it ends up costing the health system more money due to complications and worsening health outcomes. Research has found that the cost of patients not receiving optimal medication therapy is over $528 billion each year in the United States.[2]

MYTH

Copay assistance enables patients to circumvent plan design and go right to the highest-cost drugs.

FACT

Patients taking specialty medications must first go through utilization management (UM) protocols imposed by their health plan, such as prior authorization and step therapy, before being granted access to the medication their doctor has prescribed. It is only *after* receiving approval for his/her medication from the health plan that patients can request copay assistance.

MYTH

If patients don't like accumulator policies, they should be better health care consumers and choose a health plan that works better for them.

FACT

When it comes to choosing a health plan, most patients do not have a choice. Plans with copay accumulators are either all that is offered, or all they can afford. For many Americans, it all comes down to the cost of the premium, and sadly, the lowest premium plans come with the highest out-of-pocket cost burden. In fact, many employers only offer high deductible health plans (HDHPs) which can require a deductible of up to $8,700 – which many patients cannot afford without assistance.

With more than 80% of commercially insured plans having copay accumulator policies, millions of Americans are insured, but left unable to exercise their health plan benefits to get the medications they need.[3]

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MYTH

When patients are allowed to use copay assistance, they have less "skin in the game."

FACT

Patients living with chronic illnesses don't have the luxury of forgoing certain health care treatments and services. Copay assistance helps shoulder the increasingly high burden of out-of-pocket costs for needed medicines.

In recent years, **patients are being forced to pay more out of pocket than ever before.** More than half of all Americans are now in HDHPs, and the average deductible has increased 90% since 2015.[4,5] While 56% of Americans report being unable to cover an unexpected expense of over $1,000, Affordable Care Act (ACA)-compliant plans are allowed to charge $8,700 out of pocket for an individual and $17,400 for a family in 2022.[6,7] **This is not a matter of choosing smarter – it is an impossible financial situation.**

MYTH

Internal Revenue Service (IRS) guidance stands in the way of the Centers for Medicare & Medicaid Services (CMS) disallowing copay accumulator adjustor policies.

FACT

This is a misreading of the IRS guidance. **Although critics often point to 2004 IRS informal guidance as preventing CAAP bans, the guidance does no such thing.**

The IRS informal guidance itself does not address copay assistance at all. What's more, the 2004 informal guidance predated patient cost-sharing protections that were set in the ACA, prior to the emergence of accumulator adjustor policies.

The IRS has since clarified its position on the use of copay cards for enrollees on a HDHP paired with a health savings account (HSA) that wish to contribute to their HSA, stating that the enrollee is only required to meet the minimum deductible to be considered to have met their financial responsibility. **Claiming IRS rules block copay help from counting towards a patient's deductible is simply untrue and harms America's most vulnerable patients.**

To set the record straight, **CMS should require that insurers and pharmacy benefit managers (PBMs) *count all copayments made by or on behalf of an enrollee* toward that enrollee's annual deductible and out-of-pocket limit.** CMS can do this in their annual updated guidance, known as the Notice of Benefit and Payment Parameters (NBPP), which informs health insurance plan design and implementation.

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