Copay Assistance **Helps** Patients

Copay Accumulators **Hurt** Patients

In order to help vulnerable patients, especially those with chronic and rare conditions, some pharmaceutical manufacturers and nonprofit organizations provide copay assistance for innovative lifesaving medications, many which have no generic alternative, to help offset the significant out-of-pocket costs imposed by insurance companies.

Historically, the contributions from the copay assistance go toward fulfilling a patient's out-of-pocket obligations, including their deductible. Once the deductible is met, the patient pays a modest fixed copay per prescription.

Patients with disabilities and difficult diseasesare already face physical, emotional and financial hardships. The assistance provided by pharmaceutical manufacturers and nonprofit organizations provides a financial lifeline for many people living with chronic conditions.

Insurers have raised deductibles, increased use of coinsurance, and added new prescription drug formulary tiers.

- **Health insurance deductibles have skyrocketed 111% since 2010 (compared to a 19% rise in inflation)[1]**
- **Currently, the annual deductible can be as high as $8,150 for individuals and $16,300 for families with high deductible plans.[1]**
- **Two-thirds of health plans applied 40% coinsurance to their specialty drug tier, which translates to thousands of dollars in out-of-pocket costs for patients – especially because coinsurance is based on the list price rather than the discounted price the insurer pays for medicines.[2]**

Insurers Double Dip While Patients are Denied Life-Essential Medications

Many insurers and PBMs are now utilizing copay accumulators that stop copay assistance from counting towards a patient's deductible and maximum out-of-pocket spending cap. These practices are creating significant financial and health issues for patients.

With the use of copay accumulators, the patient's copay assistance is still accepted at the pharmacy and collected by the insurer; however, **the copay assistance does not count toward the patient's deductible or out-of-pocket costs**. This unfair design can be especially challenging for patients whose health plans have high deductible, copayment and/or coinsurance requirements, causing significant financial hardships and potentially harmful health outcomes for patients.

ALL of the money paid through the copay assistance, which was intended to help the patient, goes directly to the health insurance company, which double dips and gets paid TWICE — once from the copay assistance and then again by the patient's deductible.

As this trend increases, so will the harm to the health and financial well-being of Texas patients.

When patients exhaust their copay assistance but continue to face copay and coinsurance requirements, many are forced to abandon their medicine, jeopardizing their health and ultimately resulting in the use of more expensive health care services, disability, unemployment and loss of independence.

A recent survey of patients found that:

40% **did not fill their prescription when out-of-pocket costs hit $75-$125**

and

70% **left without their medicine when out-of-pocket costs hit $250[2]**

Health insurance is meant to protect patients, not pose more problems and prevent them from getting access to the life-changing medicines they need and were prescribed.

Insurers' Use of Coinsurance Shifts Even More Costs to Patients

Most insurers place specialty drugs in higher formulary tiers and charge **coinsurance**, requiring patients to pay out-of-pocket for 30%-50% of the **list** price of the drug (not the **discounted** price their health plan pays). This adds thousands of dollars in out-of-pocket costs for patients with complex chronic conditions and often forces them to abandon the treatment that improves their health.

Researchers found that:
69% of health plans required **40%** coinsurance for their specialty drug tier.[2]

Requiring patients to pay out-of-pocket based on the drug's **list price** and not the **discounted price** paid by the insurer means the **patient pays far more than 40%** of the actual cost of the medicine.[2]

After paying their premiums, some patients are required to meet a high deductible **before obtaining coverage**, and then **must pay high copayments.** State regulators have forced insurers to curb such practices citing likely discrimination.[3]

Accumulator policies **shift drug costs to patients** when health plans and PBMs prevent a patient's copay assistance amount from counting toward their deductible and maximum out-of-pocket cap.

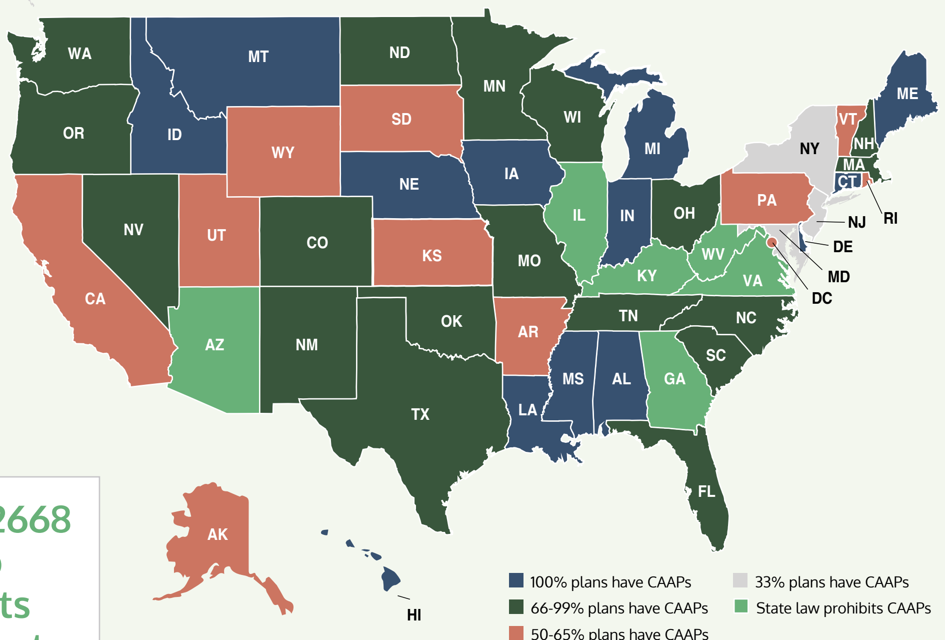
Call to Action

Currently 9 out of 10 insurers in Texas have copay accumulators. Texas lawmakers must pass legislation to address these unfair copay accumulator policies from harming patients and their families.

Six states have already stopped this discriminatory practice by passing legislation that bans accumulator policies — Arizona, Georgia, Illinois, Virginia, West Virginia, and, most recently, Kentucky — to help protect patients from high out-of-pocket costs and make sure all copays count.

Please support SB 523/HB 2668 to Stop the Double Dip and protect Texas patients from rising out-of-pocket costs.

Percent of Health Plans in States with Copay Accumulator Adjustment Programs (CAAPs)



Source: The AIDS Institute, March 2021

Sources:

[1] Kaiser Family Foundation, https://www.kff.org/health-costs/report/2020-employer-health-benefits-survey/

[2] The AIDS Institute, March 2021, http://aidsinstitute.net/documents/2021_TAI_Double-Dipping_Final-031621.pdf

[3] Colorado Division of Insurance, Bulletin No. B-4.82: Consumer Cost Share for Prescription Drugs. January 28, 2015.