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Copay Accumulator Programs: What Employers Need to Know

BACKGROUND

As health care costs in the U.S. continue to rise, an increasing amount of out-of-pocket costs are shifted onto employees. Yet, many employees have less available income due to the economic impact of the COVID-19 public health emergency. One way that employers can help is by selecting health plans that limit the use of copay accumulator programs. This fact sheet explains recent federal activity and makes recommendations to employers.

WHAT ARE COPAY ACCUMULATOR PROGRAMS?

When employees with chronic or complex conditions cannot afford their medications, they may rely on copay assistance (i.e., coupon cards from drug manufacturers). These coupon cards not only contribute toward the employee's copay but also count toward the employee's annual deductible and annual out-of-pocket limit. Copay assistance programs have been especially helpful for individuals enrolled in high deductible health plans (HDHPs) in which employees are required to pay significantly high out-of-pocket costs until their deductibles are reached. Increasingly, HDHPs are employees' only options; many employers only offer HDHPs.[1]

However, health plans are increasingly implementing copay accumulator programs, which are policies that prevent the value of the coupon from counting toward an employee's deductible or annual limit.[2]

HOW DO COPAY ACCUMULATOR PROGRAMS IMPACT EMPLOYEES?

Employees with complex health conditions often depend on copay assistance to access their medically necessary treatments. However, copay assistance is not a bottomless well. Employees can receive a finite amount each year. Once copay assistance runs out, many employees can no longer afford their medications. In many instances, there are no generic alternatives, placing employees at risk for medication adherence issues, including skipping refills, rationing medications, or abandoning treatment altogether.[3] A recent survey by Truven Health Analytics revealed that cost is the biggest barrier to

medication adherence. Nonadherent employees can face disease progression or relapse, and increased health care utilization (e.g., more visits to the doctor and hospitalization).[4] Adverse health consequences and increased financial strain add stress and anxiety to the lives of people who are already vulnerable. These consequences can lead to increased absenteeism, reduce productivity, and use of short-term or long-term disability policies.

WHY ARE COPAY ACCUMULATOR PROGRAMS USED?

Insurers use copay accumulator programs to collect the value of the financial assistance and extend the time that plan enrollees are in the deductible phase of their health plan. The longer enrollees remain in the deductible phase of the health plan, the more money that the health plan makes. However, there is no guarantee that any cost-savings will be passed on to the employer.

Health plans argue that they use copay accumulator programs to steer enrollees to lower cost, generic medications. However, health plans already use other benefit utilization management policies to achieve this goal. Insurers typically require enrollees to first try and fail on less costly alternatives (i.e., step therapy) or seek the insurer's advance approval based on their individualized needs (i.e., prior authorization) before they can access more costly medications. For example, IQVIA recently conducted a study of commercial claims data for patients who were prescribed a medication for rheumatoid arthritis or multiple sclerosis. The study found that four out of five new patient claims were subject to a benefit utilization management restriction, and nearly 30 percent of those claims were denied. Once patients were approved, copay cards were used between 50% and 60% of the time to overcome cost-sharing hurdles.[5] Once enrollees overcome these hurdles, a copay accumulator program presents an additional, unnecessary barrier to access.

Additionally, many medications for which copay assistance is available do not have generic equivalents. One study of commercial claims data found that patients only use copay assistance for brand medications that have generic equivalents 0.4% of the time.[6] In these instances, if an enrollee cannot access a brand medication, he or she generally has no other treatment option. Therefore, a more practical solution would be to only allow copay accumulator programs in instances where generic alternatives are available.

WHAT IS THE NOTICE OF BENEFIT AND PAYMENT PARAMETERS AND WHAT DID IT DO?

A. Notice of Benefit and Payment Parameters

Each year, the U.S. Department of Health and Humans Services (HHS) issues the Notice of Benefit and Payment Parameter (NBPP), which governs how health insurers

implement health plans, including Employee Retirement Income Security Act (ERISA) plans.

B. NBPP 2020

On April 25, 2019, HHS finalized the NBPP 2020. NBPP 2020 would have only allowed health plans to implement copay accumulator programs when both a brand and generic medication were available. The rule was intended to steer patients to less costly, generic medications when possible. This rule was a major win for patients with chronic, rare, and debilitating diseases who do not have access to alternative, less costly medications. While it created appropriate cost-saving incentives, it also inherently prohibited copay accumulator programs when generic alternatives were not available.

C. FAQ & IRS Bulletin No. 2004-50, Q&A-9

On August 26, 2019, HHS, Department of Labor (DOL), and Department of Treasury issued an FAQ document, announcing that they would not enforce NBPP 2020 because of a perceived conflict with an Internal Revenue Service (IRS) Bulletin from 2004 that governs HDHPs with accompanying health savings accounts (HSAs). In actuality:

- NBPP 2020 and the Bulletin **do not conflict because the agencies misinterpreted the Bulletin** (the agencies conflated third-party discount cards with pharmaceutical manufacturers' copay coupons;); and
- NBPP 2020 and the Bulletin **cannot conflict because the NBPP is legally binding, whereas the Bulletin is not**. (NBPP 2020 went through the formal notice-and-comment rulemaking process whereas the Bulletin is a guidance document that did not.)

D. NBPP 2021

On May 17, 2020, HHS finalized the **NBPP 2021**. In the **NBPP 2021**, HHS revoked NBPP 2020's copay accumulator protections. Instead, NBPP 2021 explicitly allows health plans to implement copay accumulator programs in all instances, regardless of whether a generic equivalent is available. HHS used the faulty FAQ as support for this proposed change.

WHAT IS THE PROPOSED MEDICAID RULE AND WHAT CAN EMPLOYERS DO?

A. An Overview of the Proposed Rule

In June 2020, the Centers for Medicare and Medicaid Services (CMS) introduced a proposed rule. In contrast to language used in the NBPP 2021 in which HHS claimed

copay accumulator programs were unlikely to harm patients, CMS expressly acknowledged that copay accumulator programs benefit health insurers, rather than patients. CMS noted that copay accumulator programs extend the time in which patients remain in the deductible phase of their plan, to the patients' detriment, and often, surprise. CMS also acknowledged that such programs extend the length of time that a patient is in the deductible phase of a health plan, often to the patient's surprise and detriment.

CMS proposed to modify the Medicaid Best Price Rule. The Medicaid Best Price Rule requires that drug makers give Medicaid programs the lowest price for their prescription drugs among nearly all purchasers, subject to certain exclusions.[7] Traditionally, the Medicaid Best Price Rule had excluded copay assistance based on the assumption that the patient, and not the health plan, is receiving the assistance. If the proposed rule is finalized, copay assistance would no longer be excluded from the best price calculation unless a drug maker could ensure that the patient received the assistance, rather than the health insurer.

B. Problems with the Proposed Rule

Drug makers and patients have no control over whether a health plan adopts a copay accumulator program. Additionally, health plans are often not transparent about whether they have adopted a copay accumulator program. Moreover, in light of the NBPP, health plans are more likely to adopt copay accumulator programs because HHS has given them express permission to do so. Therefore, the proposed rule sets up an impossible requirement. Given that the rule will be hard, if not impossible, to comply with, drug makers are likely to severely restrict access to copay assistance programs or abandon them altogether, thereby leaving patients with no access to vital financial aid.

WHAT HAVE STATES DONE TO ADDRESS COPAY ACCUMULATOR PROGRAMS?

Over the past few years, four states have enacted their own laws limiting the use of copay accumulator programs (i.e., Arizona, Illinois, Virginia, and West Virginia). NBPP 2021 does not preempt state laws that govern the use of copay accumulator programs in state-regulated health plans, so more may follow suit.

While plans governed by ERISA are not required to comply with state law, they are encouraged to do so as best practice

WHAT SHOULD EMPLOYERS DO?

Employers should keep in mind that they are **NOT** required to implement copay accumulator programs. They have the ability to negotiate with health insurers on whether or not to include copay accumulator programs in their plans.

A. The Proposed Medicaid Rule

The proposed Medicaid rule has not been finalized yet. While the official comment period closed on July 20, employers can still contact CMS and ask the agency not to adopt the proposed changes to the Medicaid Best Price Rule.

Additionally, employers should not select health plans with copay accumulator programs. Employers can tell insurance agents and brokers that they do not want plans that include copay accumulator programs because such programs risk employees' access to needed copay assistance and medically necessary treatments.

B. Other Recommendations

Even if the proposed Medicaid rule is not finalized, employers should still consider avoiding copay accumulator programs, especially in HDHPs, or at least offer one plan option that does not include an accumulator program. If an employer does select a plan with an accumulator program, the program should only apply to medications for which both a brand and generic are available. That way, employees have alternative options. Additionally, the plan should clearly communicate the existence of the copay accumulator program in language that is both easy to understand and easy to locate. Finally, plan enrollees should be allowed to request exceptions from the copay accumulator program when the enrollee's health care practitioner determines that the prescribed treatment is medically necessary and alternative treatments are inappropriate. Denials of the exception request should be deemed adverse benefit determinations ripe for appeal.

WHERE CAN YOU GET MORE INFORMATION?

For more information, contact Aimed Alliance:

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[1] https://www.goodrx.com/blog/the-pros-and-cons-of-high-deductible-health-plans

[2] https://www.npr.org/sections/health-shots/2018/05/30/615156632/why-some-patients-getting-drugmakers-help-are-paying-more

[3] https://www.healthaffairs.org/do/10.1377/hblog20180824.55133/full/

[4] https://ajmc.s3.amazonaws.com/_media/_pdf/AJMC_07_2019_Sherman%20final.pdf

[5] https://www.iqvia.com/locations/united-states/library/fact-sheets/prior-authorizations-and-step-therapy-impact-to-patients-in-specialty-markets

[6] https://www.iqvia.com/-/media/iqvia/pdfs/us-location-site/market-access/fact-sheet-evaluation-of-copay-card-utilization-post-loe.pdf?_=1595531474050

[7] 42 U.S.C. 1396r-8

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