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HOW A LOOPHOLE IN THE PATIENT PROTECTION AND AFFORDABLE CARE ACT CAN IMPACT ACCESS TO YOUR NECESSARY TREATMENTS

What is the Patient Protection and Affordable Care Act and what are Essential Health Benefits (EHBs)?

The Patient Protection and Affordable Care Act is a federal law that was passed in 2010 and is often referred to as the "ACA" or "Obamacare".[1] The ACA made health care affordable for many Americans by expanding the Medicaid program and providing consumers with subsidies to help lower health care premiums.[2] The ACA also requires health plans to cover 10 essential health benefits (EHBs).[3]

All contributions paid by consumers towards the cost of an EHB item or service must count towards meeting consumers' annual out-of-pocket limit.[4] However, the ACA does not address whether "cost-sharing" provided by a third party is required to be counted towards the annual out-of-pocket limit. As a result of this ambiguity, many health plans are implementing copay accumulator programs. Under these programs, the health plan accepts copay assistance from a third party for the patient's medication but does not count that contribution towards the patient's annual out-of-pocket maximum. In response, state legislatures have started passing laws to ban copay accumulator programs to ensure all assistance by or on behalf of patients counts towards meeting the patient's deductible and annual out-of-pocket limit.

10 ESSENTIAL HEALTH BENEFITS:

- Prescription Drugs
- Emergency Services
- Hospitalizations
- Pregnancy, Maternity, & Newborn Care
- Mental Health & Substance Use Disorder Services
- Ambulatory Patient Services
- Rehabilitative & Habilitative Services and Devices *(I.e. Assistive Services and Devices)*
- Laboratory Services
- Preventative and Wellness Services & Chronic Disease Management
- Pediatric Services, *Including Oral & Vision Care*

What are annual limits on cost-sharing?

The ACA established annual limits on cost-sharing to ensure patients have an expectation of the maximum amount they will have to pay for their health care within a plan year.[5] In 2022, the maximum out-of-pocket limit for an individual is $8,700 and $17,400 for a family.[6]

How are health plans and pharmacy benefit managers (PBMs) exploiting an EHB loophole in the ACA?

Some health plans and PBMs have partnered with third-party companies to distribute their specialty medications. In doing so, these third-party companies determine that certain specialty medications are considered non-EHBs. When health plans and PBMs adopt one of these programs, patients who are prescribed specialty medications are told they will have very low copayments of $0-5 if they enroll in the third-party specialty medication program. However, the plan artificially inflates the patient's copay to ensure it collects all copayment assistance available to the patient—essentially operating as a copay maximizer.[7] For example, if a manufacturer provides a patient $12,000 a year (or $1,000 a month) in assistance for a specialty medication, the plan will artificially inflate the patient's copay to $1,005 per month for that medication; but, if the individual enrolls in the third-party specialty medication program, the copay will be $5, and the insurer pockets the $1,000 difference each month.[8] Additionally, the insurer asserts that because specialty medications are not EHBs, the value of the manufacturer copay assistance received ($12,000) does not have to count towards the patient's deductible or annual out-of-pocket limit.

Typically, if a patient does not want to enroll in the third-party specialty medication program, the patient is told they must pay between a 30 percent to 70 percent coinsurance.[9] Again, because these programs designate specialty medications as non-EHBs, the patient is told any coinsurance they pay will also not count towards their deductible or annual out-of-pocket limit. The coercive nature of these program places patients in a position in which they have no option but to enroll in the third-party program. Because these programs define specialty medications as non-EHBs, patients are forced to pay thousands of dollars more per year before reaching their deductible and annual out-of-pocket limit.

How can these programs justify excluding patients' contributions from counting towards meeting their deductible and annual out-of-pocket limit?

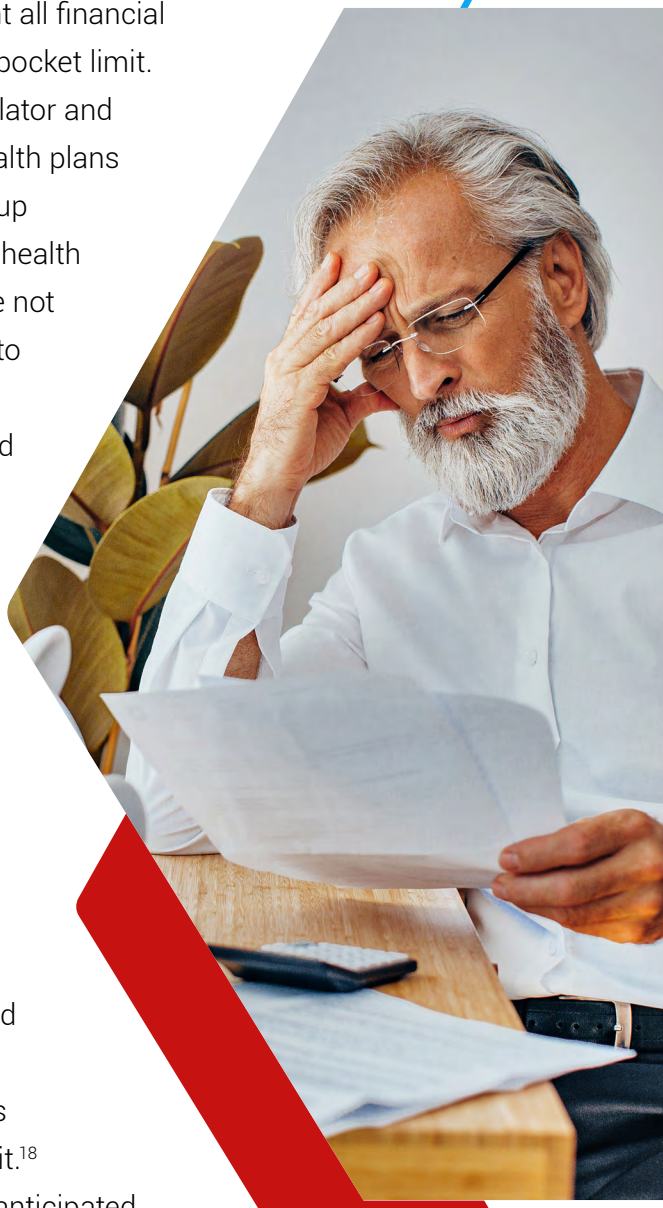
Under ACA regulations, a state a health plan provides EHBs for prescription drugs only if it "covers ***at least the greater*** of (1) one drug in every USP category and class; or (2) the same number of prescription drugs in each category and class as the benchmark plan."[10] By using the phrase "at least the greater of," the regulation sets a ***minimum*** standard for what prescription drugs a plan must cover as an EHB rather than an upper limit (i.e., it establishes a floor and not a ceiling).[11]

The ACA also requires that a health plan offer appropriate means for an individual to request and receive appropriate prescriptions that are not covered under the general plan (i.e., an exception request).[12] The exception provision also requires the plan to "treat the excepted drug(s) as an essential health benefit, including by counting any ***cost-sharing toward the plan's annual limit on cost-sharing***.[13]

The Department of Health and Human Services (HHS) has confirmed this interpretation for small and individual group plans, but has not explicitly addressed this issue for large group and employer-sponsored plans that offer EHBs.[14] While other guidance from HHS supports that this same interpretation should apply to large group and employer-sponsored health plans, many of the companies that participate in non-EHB programs argue that the ACA coverage requirements act as a ceiling, not a floor—the opposite of the interpretation above. As such, health plans have alleged that they are only required to cover the minimum number of drugs in the state plan, and everything in addition to the minimum number of medications in the state plan is considered a non-EHB.[15] This interpretation is (1) incorrect when applying the ACA regulation's plain meaning, and (2) allows health plans to remove the annual out-of-pocket protections created under the ACA because the specialty medications are considered non-EHBs.

Can laws banning copay accumulators fix the problem?

Yes! A copay accumulator ban law requires health plans to count all financial contributions towards a patient's deductible and annual out-of-pocket limit. As of 2022, 14 states have passed laws that ban copay accumulator and maximizer programs. However, these state laws only govern health plans that are regulated by state law, such as individual and small group plans, marketplace plans, and fully funded employer sponsored health plans. Employer sponsored health plans that are self-funded are not governed by state law.[16] Therefore, federal legislation is needed to prohibit copay accumulator programs and protect all patients. Fortunately, the HELP Copays Act (HR5801) has been introduced in the House of Representatives. The bill would require all contributions paid by or on behalf of the patient to count towards the patient's deductible and annual out-of-pocket limit. Importantly, it would address the EHB loophole within the ACA.[17] The HELP Copays Act would also apply to employer sponsored health plans that are self-funded.



What should I do if I am a patient enrolled in one of these programs?

If you are a patient enrolled in one of these programs, you should know that your health plan may be collecting assistance from a manufacturer or other party on your behalf but not counting this assistance towards your deductible or annual out-of-pocket limit.[18] Therefore, you may be required to pay more than you originally anticipated to reach your deductible and annual out-of-pocket limit.

For patients, it is also important to understand that many of these programs guarantee the patient has access to their medication for the entirety of the plan year.[19] However, on some occasions patients have reported being told mid-year they need to switch medications because their copay assistance program has either been exhausted or is no longer available. When this occurs, patients are essentially being switched from their medications for financial rather than medical reasons. This practice, known as non-medical switching, may jeopardize the health of patients who are stable on their current medications. If this happens to you, you should immediately review your plan materials and determine whether you are enrolled in one

of these third-party programs and, if so, closely review the program terms and conditions. If the terms guarantee you access to your medication for the entire plan year, you should immediately call your pharmacist or the third-party company and explain that you are entitled to your original medication with the same cost-sharing requirements.

What should I do if I am a health care provider who has patients enrolled in these programs?

If you are a health care provider, it is important to understand how these programs work because your office is often the first place patients call when they experience push-back from health plans or PBMs. If a patient informs you that they are subject to one of these programs and are being told they must switch medications, you should encourage them to review the terms and conditions of the specialty medication program their health plan is partnering with. Additionally, encourage the patient or caregiver to call the program and discuss the proposed switch and why the patient is entitled to their medication for the entirety of the plan year. Taking these steps will help ensure the patient can access their treatment without being required to file any additional exception paperwork.

NEED ADDITIONAL HELP?

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