**Accumulator Adjustment Program Legislation Opposition Talking Points & Counters**

**Opposition Argument:** Copay Assistance Steers Patients from Generic to Brand Name Drugs

**Counter:** A study from IQVIA of claims data from 2013-2017 shows that 99.6% of copay assistance was used for treatments without generic alternatives.[[1]](#footnote-2) In other words, brand name drugs with generic alternatives only make up 0.4% of copay assistance usage.

Insurers and pharmacy benefit managers have utilization management protocols, such as step therapy and prior authorization. These protocols ensure that patients try lower costs alternatives before receiving access to a medication that has copay assistance.

Copay assistance only becomes a factor for a medication once an insurance company has granted approval for the patient to utilize that medication.

**Opposition Argument:** Copay Assistance/Coupons Guide Patient Decision-Making

**Counter:** Copay assistance is used within the plan design of the insurers and PBMs. As stated previously, copay assistance only becomes a factor for a medication once an insurance company has granted approval for the patient to utilize that medication.

The opposition likes to describe copay assistance as “coupons” because for other products, coupons can guide decision-making on behalf of the consumer. However, coupons for other products do not have other stakeholders (i.e. insurers and pharmacy benefit managers) within the process like there is with medications. There is no one in the aisle of the grocery store telling a consumer that they have to first purchase the store-brand product before using their coupon on the brand name product.

Unlike coupons, copay assistance are real funds being transferred from one party to another. Since this issue is addressing copay assistance rather than coupons, programs like GoodRx are not impacted.

**Opposition Argument:** Insurers and PBMs Never See the Money from the Copay Assistance

**Counter:** When insurers exclude copay assistance payments from counting toward a patient’s deductible and out-of-pocket maximum, it is the insurer who is effectively paid twice. First, the copay assistance money covers what the patient owes out-of-pocket at the pharmacy. Then, because the insurer decides not to count the copay assistance payments, the insurer tells the patient (by way of the pharmacy) that the deductible has not been met. At this point, the patient has to either pay hundreds or thousands of dollars for their prescription or go home empty handed.

**Opposition Argument:** Medicare and Medicaid Do Not Allow Copay Assistance

**Counter:** Medicare and Medicaid do not allow copay assistance. However, there is a difference between an accumulator adjustment program and a ban on copay assistance. Accumulator adjustment programs restrict the funds from counting towards a patient’s cost-sharing, such as their dedituble or maximum out-ot-pocket cost.

Insurers and PBMs have attempted to equate their private companies with the federal government programs. Although Medicare and Medicaid have restrictions on copay assistance, those programs have vastly different benefit models than private plans. In 2021, deductibles in Medicare Part D may not exceed $445. By comparison, the average deductible for an ACA silver level plan this year is $4,879, with many plan deductibles climbing upwards of $7,000.[[2]](#footnote-3) It would not be an accurate or fair comparison to evaluate the models employed by insurers and PBMs against Medicare and Medicaid.

**Opposition Argument:** California and Massachusetts Ban Copay Assistance

**Counter:** California does not ban copay assistance. They do restrict copay assistance if a lower cost generic drug is covered under the individual’s health insurance. In addition, the prohibition does not apply if the patient has completed any applicable step therapy or prior authorization requirements for the branded prescription drug as mandated by the patient’s health insurance.

Despite these restrictions for assistance in California, which are geared towards ensuring patients can’t be steered towards brand name medications when there are cheaper alternatives, 6 out of 11 insurers in the state had accumulator adjustment programs in 2021. Accordingly, this is a clear example that accumulator adjustment programs aren’t about steering patients to generics but rather shifting the costs to chronic disease patients.

In 2012, Massachusetts lawmakers enacted a law allowing for the use of manufacturer discounts. Prior to that, copay assistance was not allowed in the state. The 2012 bill was passed with a sunset provision, which has repeatedly been extended by the Massachusetts legislature. These extensions of the sunset provision occur as the legislature sees the need to ensure patient’s can stay adherent on their medications. In 2021, Massachusetts passed another extension of the sunset to allow assistance, and 7 out of the 9 insurers in the state responded by implementing accumulator adjustment programs.

**Opposition Argument:** The Notice of Benefit and Payment Parameters Allow Insurers and PBMs to Use Accumulator Adjustment Programs

**Counter:** It is important to note that the most recent final Notice of Benefit Payment Parameters (NBPP) by the Department of Health and Human Services (HHS) stated that insurers/PBMs have discretion to exclude manufacturer cost-sharing from counting towards an enrollee’s annual limit on cost-sharing but that does not preempt state laws. As further described in the NBPP 2021 Final Rule, “issuers and group health plans will continue to have flexibility, subject to state law… to determine if and how to factor in direct drug manufacturer support amounts towards the annual limitation on cost sharing.”[[3]](#footnote-4) Based on its clear language, HHS’ regulation does not require states to change their policies. To the contrary, it explicitly gives states the responsibility to decide whether or not to permit accumulator adjustment programs.

**Opposition Argument:** Premiums Will Go Up if Insurers and PBMs Ensure that All Copays Count

**Counter:** In examining the justifications for rate changes in states that have enacted legislation, such as Virginia and Arizona, to ensure that all copays count, insurers gave no clear evidence that issuers were using copay accumulators to justify a rate increase. If copay accumulators are a factor in the issuers’ rate determination, it is not clearly evident in their descriptions.

Insurers have not brought forward rate changes in plans crediting the implementation of accumulator adjustment programs as a reason for premium decreases. If accumulator adjustment programs are not decreasing premiums, then there is no reason to believe that restricting them would cause premium increases.

**Opposition Argument:** Legislation to Counter-Act Accumulator Adjustment Programs Does Not Mention “Accumulator Adjustment Programs” and is Too Broad

**Counter:** The All Copays Count Coalition, led by the patient and provider community, supports language that ensures that payment paid by the patient or on behalf of the patient count towards a patient’s cost-sharing requirements. Restricting the practice of accumulator adjustment programs solely by name will only lead to insurers and PBMs not calling their practice by that name. This language also protects against future escalation by the insurers and PBMs in this space.

**Opposition Argument:** There is No Reason for Health Care Providers to Weigh-In on this Issue

**Counter:** Health care providers care about the health of their patients. Adherence is a crucial aspect of ensuring that their patients are healthy. Without copay assistance, patients could discontinue their treatment which would lead to negative health outcomes.

Also, insurers and PBMs have expressed a desire to implement accumulator adjustment programs on the medical benefit, along with the pharmacy benefit. To implement the programs on the medical benefit, insurers and PBMs have, or are considering, requiring a health care provider to disclose patient information about copay assistance to the insurers and PBMs. Askingphysicians to report on the amount their patients receive in copay assistance will put them in an ethically objectionable position. As such, reporting this information would likely harm the patient as well as the doctor-patient relationship, and would be unethical under AMA guidelines.

**Opposition Argument:** Patients Should Have “Skin in the Game”

**Counter:** This is an inaccurate claim directed at patients managing complex chronic and rare diseases. Pointing back to the shift in benefit design with high deductibles and high coinsurance, insurers have forced patients to put more and more skin in the game; and with copay accumulator adjustment programs, they are putting patients’ lives on the line. Furthermore, copay assistance is a finite amount of money; when the assistance runs out during the plan year the patient is responsible for any remaining cost-sharing, whether it is their deductible, copay, or coinsurance. Copay assistance keeps patients adherent to their treatment and out of the emergency department, which ultimately can help to control costs for the broader healthcare system.

**Opposition Argument:** This bill would conflict with IRS law

**Counter:** To comply with an IRS rule, there is language that can be added to accumulator ban bills to ensure that the ban for patient’s with HSA-HDHP goes into effect once the patient’s MINIMUM dedituble (defined by IRS law) has been paid by the patient themselves. After the patient has paid the minimum dedituble then they can go back to using co-pay assistance for the rest of their dedituble and other cost-sharing requirements.

1. IQVIA. An Evaluation of Co-Pay Card Utilization in Brands after Generic Competitor Launch. https://www.iqvia.com/locations/united-states/library/fact-sheets/evaluation-of-co-pay-card-utilization [↑](#footnote-ref-2)
2. The AIDS Institute. <http://aidsinstitute.net/documents/2021_TAI_Double-Dipping_Final-031621.pdf> [↑](#footnote-ref-3)
3. Department of Health and Human Services. Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2021; Notice Requirement for Non-Federal Governmental Plans. Vol. 85, No. 94. (5/14/2020). p. 29232. https://www.federalregister.gov/documents/2020/05/14/2020-10045/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2021 [↑](#footnote-ref-4)