POLICIES TO HELP PATIENTS PAY LESS FOR THEIR MEDICINES: MAKE ALL COPAYS COUNT

Many people with rare and chronic conditions rely on copay assistance programs to help them afford their high out-of-pocket (OOP) costs for their medication and treatment. But new tactics by health insurance companies and pharmacy benefit managers (PBMs) ban copay assistance from counting toward patient OOP cost-sharing. These tactics make it harder for patients to access essential and life-saving treatments for chronic illnesses such as asthma, diabetes, HIV, arthritis, hemophilia and others.

THE PROBLEM

In the commercial health insurance market, some patients are being forced to pay more out-of-pocket for their medicines due to an increase in deductibles and the use of coinsurance instead of copays.

Deductibles require patients to pay in full for their medicines before insurance coverage kicks in. And unlike copays, which are a fixed dollar amount charged per prescription, coinsurance requires patients to pay a percentage of the medicine's price. When patients are facing deductibles or coinsurance, they will often have higher out-of-pocket costs than when their plan requires a copay because deductibles and coinsurance are often based on the list price of the medicine and not the discounted amount the insurance company and PBM have negotiated to pay. This higher cost sharing can impact patients' ability to adhere to their prescribed treatment, which can be devastating for patients with chronic conditions who rely on medicines to keep their symptoms in check.

To help patients better access their medicine and stay adherent, many third-party entities, including pharmaceutical manufacturers, offer cost-sharing assistance. Historically, commercial health insurance plans counted this assistancetowards a patient's deductible and maximum OOP, providing relief from high cost-sharing and making it easier for patients to get their medicines.

Unfortunately, in recent years, health insurers and PBMs have adopted policies, often referred to as "accumulator adjustment programs," that block patient copay assistance from counting toward patient deductibles and maximum OOP limits. This means patients could be paying thousands more at the pharmacy than they should be.

Many patients who have relied on this assistance to access their medicines have no idea that health insurers and PBMs are no longer counting copay assistance amounts towards their OOPlimits. This can result in abandoned prescriptions when patients confront thousands of dollars in unexpected charges because their copay assistance has run out but has not been credited to the patient's required cost-sharing. Patients who can't afford to refill their prescriptions may have to discontinue treatment or turn to emergency rooms for care. Both options harm patient health and lead to higher health care spending overall.

THE SOLUTION

Make All Copays Count

South Carolina should enact a law to protect patients who rely on third-party cost-sharing assistance by ensuring that all payments – made by the patient or on behalf of the patient – count towards the patient's deductible and OOP maximum. Sixteen states, including neighboring Georgia, North Carolina, and Virginia, have already enacted legislation to address this issue.

BDASC

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