MARCH 2021

AIDSINSTITUTE.NET

Double-Dipping: Insurance Companies Profit at Patients' Expense

AN UPDATED REPORT ON COPAY ACCUMULATORS

NOTE FROM STEPHANIE HENGST, MANAGER, POLICY AND RESEARCH OF THE AIDS INSTITUTE

Soon after joining The AIDS Institute in 2017, I began to work on the topic of "copay accumulators." An initial, one-off project looking into this obscure health insurance policy has since grown into a full body of work encompassing every aspect of The AIDS Institute's mission: education, research, coalition building, advocacy, federal and state policy analysis.

With the many crises plaguing our health care system today, this very confusing issue can easily be dismissed. However, for the patients it affects, it simply cannot be ignored. And for those who haven't experienced a copay accumulator yet, it may only be a matter of time.

Health insurance is meant to protect us from high, unexpected medical costs; but when health insurance becomes the very thing preventing us from getting the medical care we need, we must make changes.

Our goal is that this report will illuminate the issue of copay accumulators generally and the problem they pose for patients specifically. It is my hope that with more attention to this matter, we as advocates can make those necessary changes; ensuring all patients can get their medications and improving the system for everyone.

Sincerely,

Stephanie Hengst

Manger, Policy and Research
The AIDS Institute

A VERY SPECIAL THANKS TO THE FOLLOWING:

Rachel Klein, Deputy Executive Director
The AIDS Institute

Melissa Griffin, Design Director,
Indigo Ink Designs

Ingrid VanTuinen, Editor
Consultant

Senior Research Assistant:

Jacqueline Weinrich

Research Assistants:

Victoria Bent

Faith Boehm

Cora Bradley

Prachi Jhawar

Noah Taylor

The AIDS Institute maintains integrity in its program and policy priorities through independence from corporate partners and sponsors. The content, research, and views represented in this report are those of The AIDS Institute.

Support for this report was generously provided by:

Introduction

Patients with rare, complex, or chronic diseases (such as HIV and hepatitis C) often need high-cost specialty medications to manage their conditions and maintain their health. Over the past decade, insurance companies have increasingly shifted the cost of care, including these specialty medications, to patients by raising deductibles and the amounts of copayments or coinsurance that patients must pay when they buy their medications.

As a result, many patients with such diseases – including those with health insurance – must rely on financial assistance from charitable foundations and drug manufacturers. Drug manufacturers' copay assistance programs play a crucial role in helping patients who rely on expensive medications meet those cost-sharing obligations and afford their medications throughout the year. These programs provide a true financial lifeline for many people living with chronic conditions.

However, insurance companies are increasingly undermining this assistance by not counting the amount of money covered by manufacturer copay assistance programs toward enrollees' annual deductibles and out-of-pocket limits, but they keep the copay assistance funds used. This little-known practice is called "copay accumulator adjustment policies" or sometimes, "CAAPs." These policies contribute to insurance company profit while shifting the cost of expensive prescription drugs back to the patients who most rely on them, and they have become more common in recent years.

Unfortunately, the federal government has recently taken action that allows copay accumulator adjustment policies to flourish: In May 2020, the Department of Health and Human Services (HHS) finalized a rule that allows health insurance companies to use copay accumulator adjustment policies at their discretion, even where there is no medically appropriate generic drug available.

Copay accumulator adjustment policies shift more costs to patients who have serious, complex, chronic illnesses and make it harder for these patients to afford the medicines they need. The public health pandemic has presented an additional economic burden for millions of Americans. As unemployment remains high across the country, many people are struggling to pay for basic things like rent and groceries. Copay accumulator adjustment policies are only adding more financial strain for patients who may be facing hardships due to the coronavirus pandemic's impact on jobs and family budgets.

Copay accumulator adjustment policies are only adding more financial strain for patients who may be facing hardships due to the coronavirus pandemic's impact on jobs and family budgets.

This report examines how widely insurance companies have adopted these policies in the health insurance plans they offered to individuals and families in the health insurance marketplace for 2021. We found that the new HHS rule has led more companies to adopt these harmful policies, which strip away the assurance that patients can afford the life-saving medicines they need.

Table of Contents

- Overview of Our Methodology
- Findings
- How Copay Assistance Works with Copay Accumulator Adjustment Policies
- Insurers Have Changed Plan Designs and Cost-Sharing in Ways That Can Harm Patients' Health
- The Impact of Copay Accumulator Adjustment Policies on Patients and Insurers
- Federal Regulation and Legislation Regarding Copay Accumulator Adjustment Policies
- States' Actions to Protect Patients' Access to Prescriptions
- Research Results Paint a Clear Picture of the Trends in Copay Accumulator Adjustment Policies
- Methodology
- Trends in Copay Accumulator Adjustment Policies
- Conclusion

Overview of Our Methodology

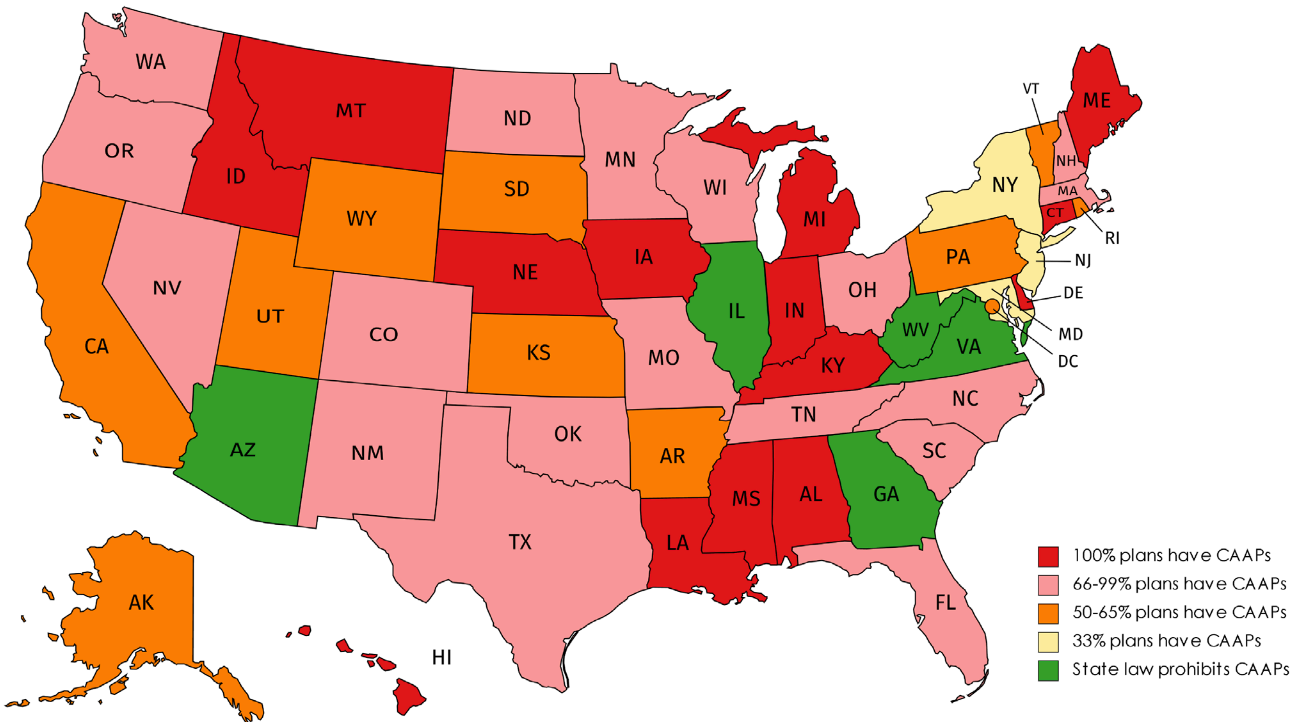
Copay accumulator adjustment policies can have an enormous impact on whether patients with HIV, AIDS, viral hepatitis, or other serious or chronic illnesses, can afford their medicines. To find out how common these programs are and how they affect patients' insurance, The AIDS Institute conducted original research, reviewing individual market[1] health plans across all 50 states and the District of Columbia for 2021. We examined all available policy documents from all insurers that offered plans in the state, looking for specific language regarding enrollee cost-sharing and copay accumulator programs. When policy documents were ambiguous or unavailable, we called customer service lines to speak with insurance plan representatives.

Findings

Our review of 2021 health insurance plans offered to individuals and families through the ACA marketplaces found that the HHS rule change has allowed copay accumulator adjustment policies to flourish.

- In 45 states and the District of Columbia, there is at least one plan with a copay accumulator adjustment policy.
  - In 14 states, **every plan** includes a copay accumulator adjustment policy: Alabama, Connecticut, Delaware, Hawaii, Idaho, Indiana, Iowa, Kentucky, Louisiana, Maine, Michigan, Mississippi, Montana and Nebraska.
  - In 32 states, **at least two-thirds** of plans include a copay accumulator adjustment policy (including the 14 listed above).[2]
  - **Maryland, New Jersey and New York are the only states where fewer than half of plans** include a copay accumulator policy.
- Five states and Puerto Rico have enacted legislation that prohibits copay accumulator policies in plans regulated by the states' departments of insurance: Arizona, Georgia, Illinois, Virginia and West Virginia.

Percent of Plans in States with Copay Accumulator Policies



...the HHS rule change has allowed copay accumulator adjustment policies to flourish.

Despite allowing insurance companies to adopt copay accumulator policies, HHS did not require the companies to make information on these policies clear for patients shopping for coverage. Our research found that this information is difficult to find, and people shopping for coverage may need to call specific insurers to learn about any copay accumulator policies. However, customer service representatives may not be able to answer accurately. In some cases, our researchers were unable to reach a representative at all, suggesting that people shopping for coverage may have the same problem.

- In seven states, no insurance companies made this information available: Alabama, Delaware, Louisiana, New Jersey, New York, South Dakota and Vermont.[3]
- Across all states examined, more than a quarter (28%) of insurers ***with* a copay accumulator adjustment policy** did not make this information available online to shoppers before they bought a plan.
- Overall, 42% of all the plans in the states we researched did not share information about whether they had a copay accumulator policy in plan materials that were available to people before enrollment.

How Copay Assistance Works with Copay Accumulator Adjustment Policies

When a patient who uses copay assistance has a health insurance plan with a copay accumulator adjustment policy, they may be confused when they have to pay the full cost of their medicines or their full deductible at the pharmacy counter, several months into the plan year. At that point, they have spent their copay assistance and will have to pay their entire deductible before they can get their prescription. Their pharmacy bill could run as high as several thousand dollars. Many patients cannot afford that and would walk away empty-handed.

Copay accumulator adjustment policies put patients with chronic conditions in a tough position – forcing them to choose between their health and other financial obligations.

Example 1 is a simplified overview of how copay accumulator adjustment policies work for patients who use copay assistance.

Copay accumulator adjustment policies put patients with chronic conditions in a tough position – forcing them to choose between their health and other financial obligations.

Example 1

- Patient has a $1,000 deductible and $500 in copay assistance.

No Copay Accumulator Adjustment Policy

The $500 copay assistance will count toward the patient's deductible.

$1,000 - $500 = $500. The patient has to pay only the remaining $500 to reach their deductible.

Copay Accumulator Adjustment Policy

The $500 copay assistance will not count toward the patient's deductible.

$1,000 - $0 = $1,000. The patient has to pay the full $1,000 to reach their deductible.

Insurers Have Changed Plan Designs and Cost-Sharing in Ways that Can Harm Patients' Health

To truly understand copay accumulator adjustment policies, it is important to look at the larger context of how insurance companies design their plans and how that affects patients' out-of-pocket costs, in addition to how well patients understand their plans and the associated costs.

Health insurance has become more complicated in recent years, which makes it especially difficult for patients with high medical needs to choose a plan that meets those needs. Even very high-quality plans often include significant cost-shifting to patients who need expensive specialty medications, and the way plans shift those costs is not always clear to patients.

Health insurance elements that create barriers for patients include:

Insurance Is Complicated

Many patients are unfamiliar with basic health insurance terms and concepts, such as the difference between a copayment (a fixed dollar amount) and coinsurance (a percentage of the drug's cost). And most patients have never heard of copay accumulator adjustment policies. On top of that, insurers often describe these policies using complicated language that is buried deep in insurance plan documents. These factors make it difficult for patients who rely on specialty medications to identify which plans available to them include a copay accumulator adjustment policy, or to shop effectively for a plan that does not include such a policy.

Insurers Are Inconsistent in The Information They Make Available to Consumers

Our research found that there is no consistency among health insurance companies regarding if and how they inform potential enrollees about any copay accumulator adjustment policies. In November 2020, as part of the Transparency in Coverage rule, the Centers for Medicare and Medicaid Services (CMS) announced a new requirement for plans and insurers to disclose whether they include copayment assistance and other third-party payments (payments made by anyone other than the patient) in their calculations of beneficiary out-of-pocket costs. However, this requirement applies just to online cost estimator tools that patients can use only after enrolling in an insurance plan.[4] Insurers are not required to provide this information to people prior to enrollment, for example, in the standardized Summary of Benefits and Coverage that is required by the ACA or in other publicly available plan information.[5]

A patient who does not know that their health plan contains a copay accumulator adjustment policy and who does not understand the complexities of that plan may not be able to afford their medicines. This could lead to financial hardship and potentially life-threatening treatment interruptions. In the case of HIV, treatment interruptions can lead to viral mutations that can cause irreversible disease progression and render particular drugs useless in the management of HIV.

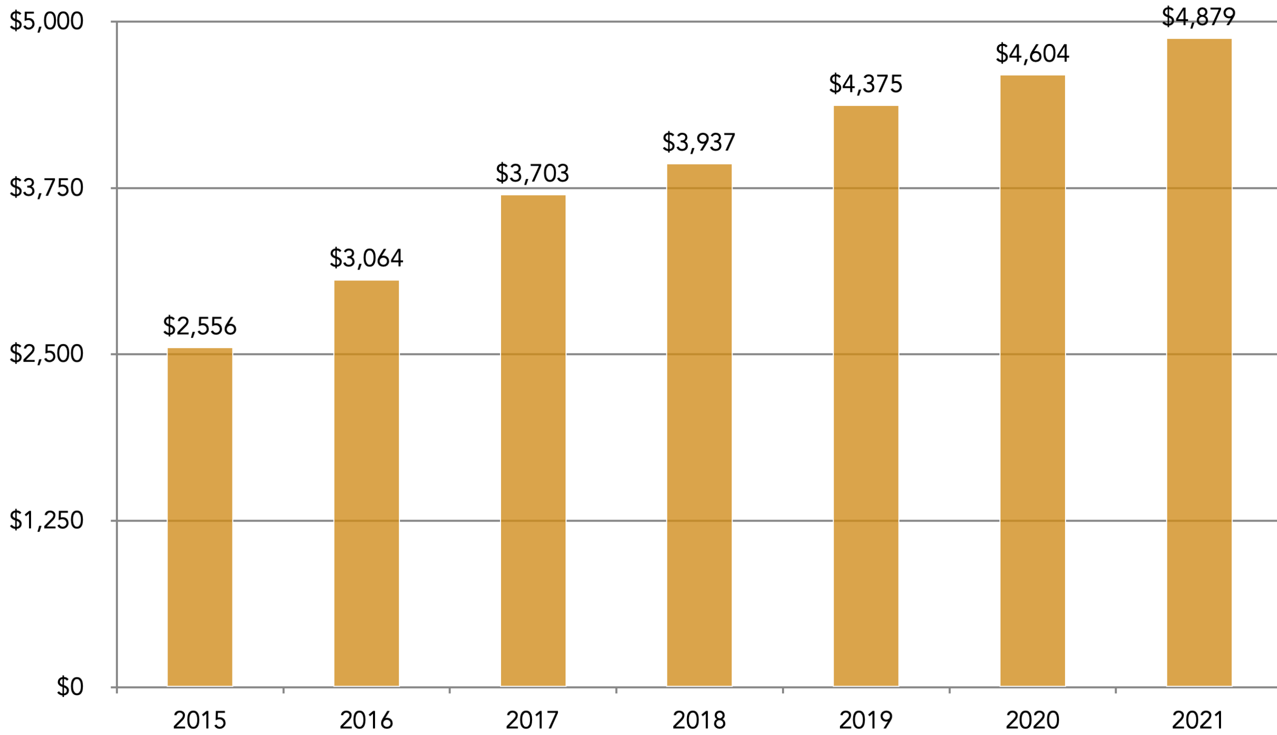
Plan Design Changes Put More Burdens on Patients

Over time, insurers have changed the structure of health insurance benefits to shift more costs to patients. For example, insurers have raised deductibles, increased use of coinsurance, and added new prescription drug formulary tiers. In 2021, the average deductible for the most popular level of health plans that offer mid-range coverage is $4,879, nearly double the average deductible of $2,556 in 2015.[6,7]

Example 2 shows how deductibles have trended up by several hundred dollars year after year.

This could lead to financial hardship and potentially life-threatening treatment interruptions. In the case of HIV, treatment interruptions can lead to viral mutations that can cause irreversible disease progression and render particular drugs useless in the management of HIV.

Example 2



In addition, more plans are moving to four or more prescription drug formulary tiers: In 2019, 84% of silver plans in the marketplace used a specialty drug tier.[8] Health insurers place many of the drugs used to treat complex diseases such as HIV, hemophilia, arthritis and epilepsy in the highest or specialty tiers, which have higher cost-sharing. So, plans with more tiers require patients to pay more out of pocket.[9]

Insurers also employ other utilization management tools such as step therapy, prior authorization and pill quantity limits, or they require enrollees to use the plan's

specialty mail-order pharmacy to keep costs low for the insurer. These techniques act as checkpoints for the insurance plan, steering patients to the preferred treatment, regardless of whether it is medically appropriate for the patient. Even after passing each of these hurdles, patients still face steep cost-sharing for specialty medicines for which copay assistance offers some financial help. On top of all the other utilization management methods that limit access to prescriptions, insurers and pharmacy benefit managers (PBMs) apply copay accumulators, driving the copay assistance dollars to the plan's bottom line and putting patients at risk.

Insurers' Use of Coinsurance Shifts Even More Costs to Patients

Higher formulary tiers often use coinsurance rather than copayments. With coinsurance, patients must pay a portion of the list price of the drug, not the discounted price their health plan has negotiated for them as their purchase price.

It is very common for insurers to charge coinsurance of 30-50% for higher tiers. One group of researchers found that 69% of plans applied 40% coinsurance to their specialty drug tier.[10] That 40% of a specialty medication's list price could translate to thousands of dollars a month for a patient with a chronic condition. And because coinsurance is based on the list price rather than the discounted price the insurer pays, patients are paying significantly more of the cost of their medication than the coinsurance percentage might indicate.

High Out-of-Pocket Costs Prevent Patients From Taking Their Medications

These high monthly costs make it more likely that patients will stop taking their medications, which could seriously worsen their health over the long term. One survey found that among people who said they did not take their medication as prescribed due to cost, 20% did not fill a prescription, and another 12% skipped doses or cut pills in half to extend their supply.[11] Not following a prescribed treatment regimen for a complicated health condition like HIV can lead to dangerous health consequences for a patient, such as irreversible worsening of their disease, hospitalization or becoming resistant to the drug. Even delaying treatment temporarily can have a dramatic impact on a patient's long-term health and end up costing the health care system more in emergency room visits or additional medical treatment. And during a pandemic, treatment delays ending in an ER stay may

put patients at greater risk for exposure to COVID-19 and increase the burden on an already-overtaxed health care system.

How much does a patient have to pay for their medicine before they opt to leave their prescription at the counter? That amount is relatively low. In a report on pharmaceutical claims, use of brand-name and generic drugs, and medication adherence, researchers found that when out-of-pocket costs reach $75-$125, more than 40% of patients leave their prescriptions at the counter. When those costs hit $250, over 70% of patients leave empty-handed.[12]

Copay assistance ensures that patients with expensive, chronic conditions can afford their medicines even with the growing out-of-pocket costs that insurers require. Copay accumulator adjustment policies remove that safety net.

The Impact of Copay Accumulator Adjustment Policies on Patients and Insurers

One argument that health insurers use to justify copay accumulator adjustment policies is that if they lower drug costs for patients, copay assistance leads patients to use higher-cost drugs, which then drives up drug prices. However, research shows (and CMS acknowledged in its regulation) that the use of copay assistance does not affect overall drug prices and does not steer patients toward more expensive drugs.[13]

Instead, this assistance helps patients afford the medications they've been prescribed. Furthermore, copay assistance makes up a tiny sliver of overall pharmaceutical claims. One group of researchers who studied the issue concluded that of all the commercial market[14] prescription purchases between 2013 and 2017, only 3.4% were bought using copay assistance, and only 0.4% had a generic equivalent.[15] Therefore, if copay assistance is used for less than 1% of purchases for medicines that have a generic equivalent, copay assistance cannot be said to drive patients to more expensive drugs.

There Are No Low-Cost Alternatives to the Prescription Drugs Used to Treat Many Chronic Diseases

For many diseases, like HIV and hepatitis C, there are no generic alternatives to brand-name medications. In addition, even when generics are available, they are still often prohibitively expensive and unaffordable for patients. As an example,

Copay assistance ensures that patients with expensive, chronic conditions can afford their medicines even with the growing out-of-pocket costs that insurers require. Copay accumulator adjustment policies remove that safety net.

for multiple sclerosis (MS), a generic drug that came on the market in 2018 was priced 20% lower than the brand-name drug – at approximately $60,000 a year.[16] Patients with complex conditions work with their health care providers to find the right treatment, and they often have conversations about whether there are lower-cost options that are medically appropriate. Moreover, when there are generic or less expensive brand drugs available, insurance plans employ utilization management techniques to limit access to more expensive medications. But even when patients make the "right choice" and opt for the lower-cost alternative, they can still find themselves in a bind, making tough choices between paying for their health care and other necessities like rent, groceries and utilities.

Health Insurers Profit from Using Copay Accumulator Adjustment Policies

Another factor that affects whether health insurers use copay accumulator policies is that they gain financially by their use. Example 3 on page 13 shows how payments for a prescription drug would work over the course of a plan year for a plan with a copay accumulator adjustment policy and a plan without one. The example shows that when a plan has a copay accumulator adjustment policy, the insurer collects significantly more money for the same medicine than it would without an accumulator adjustment policy. That additional money comes from the amount covered by the copay assistance (which is duplicated by payments from the patient).

Example 3 also shows how a patient could be surprised when, several months into the plan year, their deductible has not been reduced by the amount covered by their copay assistance. In Example 3, when the patient goes to the pharmacy in May, their copay assistance would be maxed out, and they would have to pay for the remainder of the drug's cost. The patient would continue to pay the full price of the drug each month until they reach their deductible. At that point, they'd have to pay a percentage of the full drug price (as determined by their coinsurance).

The difference between the money an insurer would collect under the two examples will vary depending on the health plan's design and the plan's specific deductible, coinsurance or copay, and annual out-of-pocket limit, as well as the cost of the prescription drug and copay assistance. However, the bottom line is consistent: The insurer makes more money when a copay accumulator adjustment policy is part of the health plan.[17]

The insurer makes more money when a copay accumulator adjustment policy is part of the health plan.

Example 3

- Plan deductible: $4,600
- Annual out-of-pocket maximum: $8,550
- Cost-sharing for specialty tier prescription: 50% *after deductible is met*
- Monthly medication cost: $1,680
- Copay assistance total: $7,200

Scenario 1: Plan *Without* a Copay Accumulator Program

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total	Insurer collects
Copay Assistance	$1,680	$1,680	$1,240	$840	$840	$840	$80	$0	$0	$0	$0	$0	$7,200	
Remaining Deductible	$2,920	$1,240	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0		$8,550
Consumer Pays	$0	$0	$0	$0	$0	$0	$760	$590	$0	$0	$0	$0	$1,350	

Deductible is met Copay assistance limit is met Out-of-Pocket maximum is met

Scenario 2: Plan *With* a Copay Accumulator Program

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total	Insurer collects
Copay Assistance	$1,680	$1,680	$1,680	$1,680	$480	$0	$0	$0	$0	$0	$0	$0	$7,200	
Remaining Deductible	$4,600	$4,600	$4,600	$4,600	$3,400	$1,720	$40	$0	$0	$0	$0	$0		$15,160
Consumer Pays	$0	$0	$0	$0	$1,200	$1,680	$1,680	$40	$840	$840	$840	$840	$7,960	

Deductible is met Copay assistance limit is met Out-of-Pocket maximum is met

Federal Regulation and Legislation Regarding Copay Accumulator Adjustment Policies

In April 2019, HHS took action against copay accumulator adjustment policies: It released the 2020 "Notice of Benefit and Payment Parameters." This federal rule, which HHS updates annually, contained a provision that required insurance companies to count copay assistance from drug companies toward patients' deductibles and out-of-pocket limits in most cases.[18,19] This rule applied to all plans sold in the individual and group insurance markets, and also to large employers that fund their own employee health insurance programs.

While a broad ban on all copay accumulator adjustment policies would have provided the best patient protection, this final rule was still a significant win for patients and patient advocates.

Unfortunately, in August 2019, HHS announced that it would delay enforcement of its new rule until 2021.[20,21] Much to the dismay of patient advocates, in its final 2021 Notice of Benefit and Payment Parameters (released in May 2020), HHS reversed its original stance on patient copay assistance: The notice permits insurers to use copay accumulator adjustment policies whenever they want, and without restrictions.[22] Furthermore, the final rule removes the protection for copay assistance in cases where no medically appropriate generic drug is available. This is a devastating blow to patient access and puts those who rely on specialty medications in a precarious position.

HHS published this final rule at the height of the first wave of the coronavirus public health pandemic, a move that seemed particularly insensitive as millions of people were laid off from their jobs and financial security became a very real threat. HHS' decision adds to the hardship for patients struggling to afford their medications during this unprecedented time.

An Executive Order issued by the White House on January 28, 2021 requires all federal agencies to review existing regulations, guidance documents, and policies to identify those that may create unnecessary barriers to health care or reduce the affordability of coverage, and instructs the agencies to develop plans to remove those barriers. We urge the Biden Administration to take regulatory action either as prat of the annual Notice of Benefit and Payment Parameters process or the implementation of the Executive Order on Strengthening Medicaid and the Affordable Care Act to reverse authorization of copay accumulator adjustment policies.

Federal Regulation and Legislation Timeline

Timeline	Summary	Policy Vehicle
April 2019	The 2020 Notice of Benefit & Payment Parameters (NBPP), finalized in April 2019, included a provision that stated health plans must count manufacturer copay assistance toward the beneficiary's deductible and out-of-pocket costs for a brand drug where no generic equivalent is available. The provision also outlined the requirement to count manufacturer assistance for generic prescriptions through an appeals process.	2020 NBPP
August 2019	In August 2019, HHS and the Dept of Labor and Treasury Dept issued and FAQ about ACA Implementation. This announced CCIIO's decision to delay enforcement of the copay accumulator provision of the 2020 NBPP, citing a possible conflict with a 2004 IRS rule related to high-deductible health plans.	Tri-Agency FAQ
May 2020	The 2021 NBPP finalized in May 2020 reversed HHS' official policy on copay accumulators, leaving it to the discretion of health plans whether or not to count manufacturer copay assistance toward a beneficiary's cost-sharing responsibilities.	2021 NBPP
July 2020	Legislation was introduced in July 2020 in the House that would delay the implementation of the 2021 NBPP due to coronavirus pandemic.	HR 7647

States' Actions to Protect Patient Access to Prescriptions

While the federal government has not prohibited copay accumulator adjustment policies, the 2021 Notice of Benefit and Payment Parameters allows states to prohibit copay accumulator adjustment policies if they choose. The growing number of copay accumulator policies, combined with the lack of federal patient protections, has motivated more states to act. States now have an opportunity to take the lead on ensuring that patients have access to prescription medicines.

Throughout the 2019 and 2020 legislative sessions, several states introduced bills to address the issue of copay accumulator adjustment policies. These states' legislators recognized how important copay assistance is and the harm that copay accumulator adjustment policies can inflict.

- To date, three states and one U.S. territory have enacted laws requiring insurers to count all copayments made by or on behalf of enrollees toward their annual deductibles and out-of-pocket limits: Illinois, Virginia, West Virginia and Puerto Rico.
- In addition, Arizona and Georgia enacted bills that prohibit copay accumulator adjustment policies for prescription drugs when no generic alternative is available but allow insurers to exclude copay assistance for a brand-name drug when a generic equivalent is available.

As state legislatures gathered for their 2021 sessions, several states had already begun to build on the work started in prior sessions. And many additional states are prioritizing copay assistance bills. States where patient advocates are building grassroots support and working with key legislators early in 2021 include Colorado, Connecticut, Florida, Kentucky, Maryland, Ohio, Oregon, Pennsylvania, Rhode Island, South Dakota and Texas.

The growing number of copay accumulator policies, combined with the lack of federal patient protections, has motivated more states to act.

State Legislation Passed

Plan	Copay Accumulator Language	Source
Arizona	This law requires that financial assistance from outside parties, including drug manufacturers, count towards an enrollee's total out-of-pocket maximum when there is no generic version of their prescription medication available, or when the patient has received permission to take the name brand drug through prior authorization, step therapy, or an issuer's appeals process.	Arizona HB2166
Georgia	When calculating an insured's contribution to any out-of-pocket maximum, deductible, or copayment responsibility, a pharmacy benefits manager shall include any amount paid by the insured or paid on his or her behalf through a third-party payment, financial assistance, discount, or product voucher for a prescription drug that does not have a generic equivalent or that has a generic equivalent but was obtained through prior authorization, a step therapy protocol, or the insurer's exceptions and appeals process.	Georgia SB313
Illinois	A health care plan shall apply any third-party payments, financial assistance, discount, product vouchers, or any other reduction in out-of-pocket expenses made by or on behalf of such insured for prescription drugs toward a covered individual's deductible, copay, or cost-sharing responsibility, or out-of-pocket maximum associated with the individual's health insurance.	Illinois HB0465
Virginia	When calculating an enrollee's overall contribution to any out-of-pocket maximum, deductible, copayment, coinsurance, or other cost-sharing requirement under a health plan, a carrier shall include any amounts paid by the enrollee or paid on behalf of the enrollee by another person.	Virginia SB1596
West Virginia	When calculating an insured's contribution to any applicable cost sharing requirement, including, but not limited to, the annual limitation on cost sharing subject to 42 U.S.C. §18022(c) and 42 U.S.C. § 300gg-6(b): (1) An insurer shall include any cost sharing amounts paid by the insured or on behalf of the insured by another person; and (2) A pharmacy benefits manger shall include any cost sharing amounts paid by the insured or on behalf of the insured by another person.	West Virginia HB2770
Puerto Rico	Any health insurance organization or insurer that provides prescription drug benefits, a pharmacy provider or benefit manager shall include in the calculation or requirement of cost sharing or cost-of-pocket maximum , any payment, discount or item that is part of a financial assistance program, discount plan, coupons, or any contribution offered to the insured by the manufacturer. These items shall be considered for the sole benefit of the patient in the calculation of his contribution, out-of-pocket expenses, copayments, co-insurance, deductible or in compliance with shared contribution requirements. These contributions, discounts, coupons will be available and may be used at all health care providers, in a ccordance with program requirements, regardless of where the discount or coupon is acquired. The use of the benefit accumulator, maximizer or any other similar program that has the effect of implementing a restriction on liability set forth in this s ubparagraph is prohibited.	Puerto Rico S.1658

Research Results Paint a Clear Picture of the Trends in Copay Accumulator Adjustment Policies

To document health insurers' copay accumulator adjustment policies and provide an estimate of how broadly these practices had spread, The AIDS Institute reviewed a sample of 2020 health insurance marketplace plans in all 50 states and the District of Columbia for a previous report. The review revealed that copay accumulator adjustment policies had spread among insurers in the individual market: 35 states and the District of Columbia had at least one insurer that sold plans for the 2020 plan year that contained a copay accumulator adjustment policy. These results confirmed that copay accumulator adjustment policies are common, and that many patients were left with no options to select a plan that would honor their copay assistance as intended.

We tracked the trends in health plan benefit design from last year to this year, expanding our review to all plans offered in all state marketplaces. The results of the review of 2021 marketplace plans are sadly not surprising: The only states in which there are no plans that include copay accumulator adjustment policies are those that have enacted legislation prohibiting them. Clearly, this practice has grown in the wake of HHS' changing policy and a lack of broad regulation.

Our review also found that language about these programs and the ways that insurance companies implement them can be complex and difficult for people to understand.

Methodology

The AIDS Institute examined 45 states and the District of Columbia. We excluded five states from our research because they had laws that required insurers to include copay assistance in the calculation of beneficiary cost-sharing. (Those states are Arizona, Illinois, Georgia, Virginia and West Virginia.) In those 45 states, we investigated copay accumulator adjustment policies for all of the insurers that offered plans in their exchanges.

In every state except Maryland, New Jersey and New York, at least half of insurers had copay accumulator adjustment policies. In 30 states, at least two-thirds of the insurers that participated in their marketplace had copay accumulator adjustment policies. The following 13 states do not have any plans without a copay accumulator adjustment policy: Alabama, Connecticut, Delaware, Hawaii,

The results of the review of 2021 marketplace plans are sadly not surprising: The only states in which there are no plans that include copay accumulator adjustment policies are those that have enacted legislation prohibiting them.

Idaho, Indiana, Iowa, Kentucky, Louisiana, Maine, Michigan, Mississippi and Montana.

While we focused on insurers in the individual market because information on their health plan policies is more accessible, copay accumulator adjustment policies also exist in employer-sponsored health plans. Almost half (49.6%) of Americans who have health insurance are covered by employer-sponsored health insurance.[23] Therefore, decisions made by employers about pharmacy benefit design have the potential to affect a much greater number of patients.

With employers concerned about rising health care expenditures, they have increasingly turned to cost control mechanisms. A 2019 survey of a sample of large employers found that 34% were already using copay accumulator adjustment policies, and an additional 4% sought to add them in the next year, a significant increase over previous years.[24] The three largest pharmacy benefit managers are now marketing copay accumulator adjustment policies to employers that are designing their insurance plans,[25] which may be contributing to their increasing prevalence. However, the decision of how to balance reduced costs and employees' health is ultimately up to employers.

An additional reason to be concerned about copay accumulator adjustment policies in employer-sponsored health insurance plans is that most of the large plans do not have to follow state insurance laws. Therefore, even in states that have banned copay accumulator programs, a significant number of residents may still be enrolled in health insurance plans that have such programs.[26]

It will take federal regulatory or legislative action to truly protect patients from copay accumulator policies.

Trends in Copay Accumulator Adjustment Policies

When comparing some of the states from plan years 2020 to 2021, many that had adjusted to align with the 2020 Notice of Benefit and Payment Parameters (which required insurers to count manufacturer copay assistance toward patient deductibles for a brand-name drug when there was no generic equivalent) have since reinstated more restrictive policies on copay assistance in their plans. For example, in Florida, Ambetter adopted a more severe policy stance, moving from permitting copay assistance to count toward deductibles and maximum out-of-pocket costs when there was no generic alternative in 2020 to refusing to apply any payments made via copay assistance toward the patient's cost-sharing in 2021.

Clearly, insurers have taken advantage of the liberties granted by the federal government through recent regulations to line their pockets at the expense of patients.

Our comparison revealed these trends:

Information Was Difficult to Find

We faced many challenges when trying to obtain the relevant information, encountering barriers to materials at multiple levels. Insurers are not required to post copay accumulator policies in the Summary of Benefits and Coverage, nor are they required to share the full policy documents during open enrollment. This meant that finding the correct policy document that contained specific information on accumulator adjustment policies often required extensive searching on a health insurer's website, with lots of trial and error. And some insurers require shoppers to already have an enrollment ID to gain access to policy documents.

Across all the insurers we researched, almost half did not have crucial information about copay accumulator adjustment policies in a format that was accessible to shoppers. This included insurers where documents were missing entirely, where information was missing in documents, or where documents were available to members only after they had enrolled. Notably, this category includes **more than a quarter of insurers with a copay accumulator adjustment policy; this group of insurers did not make this information available anywhere in writing to people before they bought a plan.** In seven states, no insurers made this information available online: Alabama, Delaware, Louisiana, New Jersey, New York, South Dakota and Vermont.

Unfortunately, customer service representatives that we reached by phone were not always familiar with this issue either. When we asked if copay assistance would count toward a plan's deductible, answers varied, and sometimes the representative simply stated they were not sure what the insurer's stance was on the matter. This shows how difficult it would be for patients to find and understand that information and then use it to make health care decisions.[27]

The Language Used to Describe Copay Accumulator Adjustment Policies Is Confusing

As we found in our previous study, the language insurers used to describe their copay accumulator adjustment policies in 2021 health plans was confusing. This leaves insured patients who use copay assistance uncertain of whether that assistance will count toward their deductible. Example 4 shows two samples of the exact language we found in insurers' 2021 plan documents.

Example 4

If you participate in certain drug cost-share assistance programs offered by drug manufacturers or other third parties to reduce the cost-share (copayment, coinsurance) you pay for certain specialty drugs, the reduced amount you pay ***may be the amount we apply*** *to your deductible and/or out-of-pocket limit when the specialty drug is provided by a network provider. Your eligibility to participate in such programs is dependent on the program's applicable terms and conditions which may be subject to change from time to time. We may discontinue such reduced amounts to your cost sharing at any given time.*

We ***may not*** *apply manufacturer or provider cost share assistance program payments (e.g., manufacturer cost share assistance, manufacturer discount plans, and/or manufacturer coupons) to the Deductible or Out-of-Pocket maximums.*

These issues regarding the difficulty of finding information about copay accumulator programs were not simply annoyances in the research process. Rather, they could mean patients are unable to find any information about copay accumulator adjustment policies before experiencing them firsthand when they try to buy their prescriptions.

CMS has taken steps to make information on health insurance easier to find and understand by requiring insurers to develop more consumer-friendly language and support tools and by including information on copay accumulator adjustment policies. The agency did this based on the principle that if consumers are given clear, concise information about cost-sharing, they will be empowered to make smart decisions about their health care.[28]

However, there is a flaw in the cost estimator tool that CMS required insurers to develop: It will be available only to those enrolled in a plan. CMS should require insurers to provide easily accessible information about copay accumulator programs in plain language to ensure that patients can understand their health insurance options up front.

What Insurers Are Doing in 2021

We found that, in 2021, insurers are following a variety of policy directions and have reacted to the changes in the 2020 and 2021 Notice of Benefits and Payment Parameters in different ways.

- Since the publication of the final 2021 Notice of Benefit and Payment Parameters, some insurers allowed copay assistance to count toward patient deductibles and out-of-pocket costs under certain circumstances.
- Many insurers broadly prohibit copay assistance from counting toward the patient's cost-sharing.
- Some insurers changed their policies from aligning with the 2020 Notice of Benefits and Payment Parameters (which allowed them to count copay assistance toward patient deductibles) to prohibiting all copay assistance from counting toward patient deductibles in 2021.

This provides evidence that, given discretion to count copay assistance toward patient out-of-pocket costs or not, more insurers will choose not to – which helps boost their profits.

Finally, since there is no standardization across insurers on where and how the information on copay accumulator policies should be communicated, our review of 2021 health plans makes clear that generalizations about an insurer's policy cannot be based on the findings in one state alone. Even among insurers that offer plans across several states, there can be significant differences in which documents are available to shoppers, whether plan documents mention copay accumulator adjustment policies at all, and the clarity of the language that insurers use to explain their copay accumulator adjustment policies. For example, an insurer that sold plans in Missouri had copay accumulator adjustment policies, but the same insurer sold plans in Kansas that did not have such policies.

All of these factors make the issue of copay accumulator adjustment policies even more complex. And that makes it difficult for patients, advocates and other stakeholders to understand the issue, explain it, or develop strategies to protect patients from high prescription costs.

Conclusion

Our review of the health plans sold in the individual health insurance market in 2020 and 2021 provides evidence that use of copay accumulator adjustment policies is growing, with more insurers in more states adopting these policies. As this trend increases, so will the harm to patients' health and financial well-being. If insurers do not significantly change the way they design health plan benefits, patients will continue to need copay assistance to afford their medicines.

At the most basic level, copay accumulator adjustment policies insert patients in the middle of the ongoing drug pricing debate between manufacturers, pharmacy benefit managers (PBMs), and insurers. Using patients as leverage in this debate does nothing to rein in industry pricing – it simply puts the most vulnerable patients in harm's way. And the coronavirus pandemic has piled additional, unprecedented stresses on patients and exacerbated the difficulties they encounter affording their prescription medications when faced with the complexities of copay accumulator adjustment policies.

All of these factors make the issue of copay accumulator adjustment policies even more complex. And that makes it difficult for patients, advocates and other stakeholders to understand the issue, explain it, or develop strategies to protect patients from high prescription costs.

There are several ways that either the federal government or state governments can solve this problem.

- HHS can reverse its 2021 Notice of Benefit and Payment Parameters rule that allowed insurers not to count the value of copayments made by, or on behalf of, patients toward their deductible and annual out-of-pocket limit.
- Congress can pass legislation that requires insurers and pharmacy benefit managers to count third party payments, including copay assistance, toward patient deductibles and annual out-of-pocket limit.
- States can continue to protect residents with health insurance subject to state regulation by enacting legislation that requires insurers to count third party payments, including copay assistance, toward patient cost-sharing limits.
- Through outreach and education, there is an opportunity for advocates to inform legislators, insurance regulators, employers, and policy makers about copay accumulator adjustment policies and to help them understand the impact these policies have on their patients' ability to maintain their health.

All of these measures would help to protect patients' access to necessary, life-saving medicines.

Though this problem has grown in scope over the past year, pushback from advocates and state legislatures has also intensified. In partnership with other patient advocacy groups, The AIDS Institute will continue to raise awareness and press for these crucial changes to be enacted.

1 Individual market: The health insurance market for coverage available to people who do not get health coverage through their employer or a government program, which is bought directly from an insurer. Health plans sold through the Affordable Care Act marketplaces are called "qualified health plans" or QHPs and they have been reviewed for compliance and verified to be sold on the marketplace.

2 States that have at least 66% or more of insurance plans with copay accumulator policies include: AL, CO, CT, DE, FL, HI, IA, ID, IN, KY, LA, ME, MA, MI, MN, MS, MO, MT, NE, NV, NH, NM, NC, ND, OH, OK, OR, SC, TN, TX, WA, WI.

3 Information on copay accumulator policies was gathered by calling each insurer's customer service line.

4 Centers for Medicare and Medicaid Services, *Transparency in Coverage Final Rule Fact Sheet (CMS-9915-F)* (CMS newsroom, October 29, 2020). https://www.cms.gov/newsroom/fact-sheets/transparency-coverage-final-rule-fact-sheet-cms-9915-f.

5 Summary of Benefits and Coverage: A templated form that provides a simplified overview of the plan's benefits and sample out-of-pocket costs for covered services.

6 Katie Keith, "Premiums Drop Slightly as 2021 Open Enrollment Period Draws Near," *Health Affairs Blog*, October 23, 2020. https://www.healthaffairs.org/do/10.1377/hblog20201023.33540/full/#:~:text=At%20the%20same%20time%2C%20deductibles,rose%20from%20%241%2C432%20to%20%241%2C533.

7 Caroline F. Pearson, Elizabeth Carpenter, and Chris Sloan. *Plans with More Restrictive Networks Comprise 73% of Exchange Market* (Avalere, November 20, 2017). https://avalere.com/press-releases/plans-with-more-restrictive-networks-comprise-73-of-exchange-market.

8 K. Hempstead, *Marketplace Pulse: Cost-Sharing for Drugs Rises Sharply at Higher Tiers* (Robert Wood Johnson Foundation, March 1 2019). https://www.rwjf.org/en/library/research/2019/03/cost-sharing-for-drugs-rises-sharply-at-higher-tiers.html.

9 Cost-sharing: The portion of costs the enrollee pays out of pocket for insurance, such as deductibles, copayments, or coinsurance, but not premiums.

10 K. Hempstead, *Cost-Sharing for Drugs Rises Sharply at Higher Tiers.*

11 Ashley Kirzinger, Lunna Lopes, Brian Wu, and Mollyann Brodie. *KFF Health Tracking Poll -February 2019 Prescription Drugs*. (Kaiser Family Foundation, March 1, 2019). https://www.kff.org/health-costs/poll-finding/kff-health-tracking-poll-february-2019-prescription-drugs/

12 IQVIA, *Medicine Use and Spending in the U.S.: A Review of 2019 and Outlook to 2023* (IQVIA, May 2019), https://www.iqvia.com/insights/the-iqvia-institute/reports/medicine-use-and-spending-in-the-us-a-review-of-2018-and-outlook-to-2023

13 IQVIA, *Medicine Use and Spending in the U.S.: A Review of 2019 and Outlook to 2023* (IQVIA, May 2019), https://www.iqvia.com/insights/the-iqvia-institute/reports/medicine-use-and-spending-in-the-us-a-review-of-2018-and-outlook-to-2023

14 Commercial market: The insurance not provided by a government program.

15 IQVIA, *An Evaluation of Co-Pay Card Utilization in Brands After Generic Competitor Launch (IQVIA, 2018)* https://www.iqvia.com/locations/united-states/library/fact-sheets/evaluation-of-co-pay-card-utilization

16 Charlotte Huff, "MS Drugs: Expensive, Often Lifelong, and Not Cost Effective." *Managed Care*, September 30, 2018, https://www.managedcaremag.com/archives/2018/10/ms-drugs-expensive-often-lifelong-and-not-cost-effective

17 Prescription Costs, Health Plan Design, and Copay Assistance Tables: These scenarios also do not take into account the discount that the insurer receives through negotiations with the drug's manufacturer. This discount – in the form of a rebate – adds to the insurer's net gains, since those savings are not passed on to patients.

18 U.S. Department of Health & Human Services, *Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2020 (HHS, April 25, 2019), https://www.federalregister.gov/documents/2019/04/25/2019-08017/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2020.*

19 The NBPP permitted exclusions where a generic equivalent is available and medically appropriate, but it also allowed for an exceptions and appeals process for patients who need the brand-name version of a drug.

20 U.S. Department of Health & Human Services, *FAQs About Affordable Care Act Implementation Part 40.* (HHS, August 26, 2019), https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQs-Part-40.pdf

21 The FAQ cited a conflict with IRS guidance pertaining to health savings accounts as the reason for HHS' delay in enforcement of the rule.

22 U.S. Department of Health & Human Services. *Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2021. Federal Register* February 2, 2020, https://www.federalregister.gov/documents/2020/02/06/2020-02021/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2021

23 Kaiser Family Foundation, *Health Insurance Coverage of the Total Population,* (Kaiser Family Foundation, 2020), https://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

24 Kelsey Waddill, *Employers Focus on High-Cost Claims, Drug Spending into 2020* (Xtelligent Healthcare Media, August 15, 2019), https://healthpayerintelligence.com/news/employers-focus-on-high-cost-claims-drug-spending-into-2020

25 Aimed Alliance, *An Update on Copay Accumulator Policies.* (Aimed Alliance, 2019), https://aimedalliance.org/an-update-on-copay-accumulator-policies/

26 Aimed Alliance, *An Update on Copay Accumulator Policies.*

27 The AIDS Institute, *States' Copay Accumulators Plan Language* (The AIDS Institute, January 2019), http://theaidsinstitute.org/sites/default/files/attachments/State%20Copay%20Accumulator%20Plan%20Slides%201.10.19.pdf

28 Centers for Medicare and Medicaid Services, *Transparency in Coverage Proposed Rule CMS-9915*

Appendix

2021Copay Accumulator Data Collection Appendix

State	Insurer	CAAP: Y/N	Policy Confirmed
Alabama	BCBS	Yes	Confirmed via phone by customer service representative.
	Bright Health	Yes	Confirmed via phone by customer service representative.
Alaska	Premera (BCBS)	No	Confirmed via phone by customer service representative.
	Moda	Yes	Policy
Arizona	State law in place		
Arkansas	AK BCBS (USAble Mutual)	No	Confirmed via phone by customer service representative.
	Centene/Ambetter	Yes	Evidence of Coverage
	QualChoice Life and Health	Yes	Evidence of Coverage
	QCA Health Plan	Yes	Evidence of Coverage
	Health Advantage	No	
California	CCHP	No	Evidence of Coverage
	Health Net	Yes	Policy
	Kaiser Permanente	Yes	Confirmed via phone by customer service representative.
	LA Care Health Plan	No	Summary of Benefits and Coverage
	Molina	Yes	Summary of Benefits and Coverage
	Oscar	Yes	Evidence of Coverage
	Sharp Health	No	Confirmed via phone by customer service representative.
	Valley Health Plan	Yes	Confirmed via phone by customer service representative.
	Western Health Advantage	No	Confirmed via phone by customer service representative.
	Anthem	Yes	Evidence of Coverage
	BlueShield	No	Confirmed via phone by customer service representative.
Colorado	Anthem	Yes	Evidence of Coverage
	Bright Health	Yes	Confirmed via phone by customer service representative.
	Cigna	Yes	Confirmed via phone by customer service representative.
	Denver Health Medical Plan	Yes	Confirmed via phone by customer service representative.
	Friday Health	No	Confirmed via phone by customer service representative.
	Kaiser	No	Confirmed via phone by customer service representative.
	Rocky Mountain	Yes	Confirmed via phone by customer service representative.
	Oscar	Yes	Evidence of Coverage
Connecticut	Anthem	Yes	Handbook
	ConnectiCare Benefits, Inc.	Yes	Confirmed via phone by customer service representative.
D.C.	Kaiser Permanente	No	Evidence of Coverage
	Care First	NBPP*	Contract
Delaware	Highmark	Yes	Confirmed via phone by customer service representative.
	Ambetter	Yes	Evidence of Coverage
	AvMed	Yes	Schedule of Benefits
	Bright Health	NBPP*	Evidence of Coverage

Florida	Cigna	No	Confirmed via phone by customer service representative.
	Florida Blue	Yes	Plan Contract
	Florida Health Care Plan	Yes	Evidence of Coverage
	Health First	Yes	Evidence of Coverage
	Florida Blue HMO (BCBS)	Yes	Plan Contract
	Molina	NBPP*	Schedule of Benefits
	Oscar	Yes	Evidence of Coverage
Georgia	State law in place		
Hawaii	HMSA	Yes	Guide to Benefits
	Kaiser	Yes	Evidence of Coverage
Idaho	Blue Cross	Yes	Summary of Benefits and Coverage
	Mountain Health CO-OP	Yes	Contract
	SelectHealth	Yes	Plan Contract
	PacificSource	Yes	Schedule of Benefits
	Regence BS	Yes	Schedule of Benefits
Illinois	State law in place		
Indiana	Celtics Insurane Co. (Ambetter)	Yes	Evidence of Coverage
	CareSource	Yes	Evidence of Coverage
Iowa	Medica	Yes	Policy of Coverage
	Wellmark Health Plan	Yes	Outline of Coverage
Kansas	Medica	Yes	Schedule of Benefits
	BCBS	Yes	Confirmed via phone by customer service representative.
	Ambetter from Sunflower Health (Centene)	Yes	Evidence of Coverage
	Oscar	No	Evidence of Coverage
	Cigna	Yes	Outline of Coverage
Kentucky	Anthem	Yes	Evidence of Coverage
	CareSource	Yes	Confirmed via phone by customer service representative.
Louisiana	BCBS	Yes	Confirmed via phone by customer service representative.
	HMO LA (BCBS)	Yes	Confirmed via phone by customer service representative.
	Vantage Health Plan	Yes	Confirmed via phone by customer service representative.
	Christus Health Plan	Yes	Confirmed via phone by customer service representative.
Maine	Anthem	Yes	Evidence of Coverage
	Community Health Options	Yes	Confirmed via phone by customer service representative.
	Harvard Pilgrim	Yes	Confirmed via phone by customer service representative.
Maryland	UnitedHealthcare	Yes	Policy
	CareFirst BCBS	No	Confirmed via phone by customer service representative.
	Kaiser	No	Confirmed via phone by customer service representative.
	United Healthcare	Yes	Policy
	Harvard Pilgrim Health Care	Yes	Confirmed via phone by customer service representative.
	BCBS	Yes	Confirmed via phone by customer service representative.
	Tufts HMO	No	Confirmed via phone by customer service representative.

Massachusetts	AllWays Health Partners	Yes	Confirmed via phone by customer service representative.
	Health New England	Yes	Confirmed via phone by customer service representative.
	Fallon Community Health Plan	Yes	Confirmed via phone by customer service representative.
	Boston Medical Center HealthNet	Yes	Confirmed via phone by customer service representative.
	Tufts Health Public Plans	No	Confirmed via phone by customer service representative.
Michigan	Blue Care Network	Yes	Schedule of Benefits
	BCBS	Yes	Schedule of Benefits
	McLaren Health	Yes	Certificate of Coverage
	Meridian	Yes	Evidence of Coverage
	Molina	NBPP*	Schedule of Benefits
	Physicians Health Plan	Yes	Confirmed via phone by customer service representative.
	Priority Health	Yes	Confirmed via phone by customer service representative.
	Total Health Care USA	Yes	Confirmed via phone by customer service representative.
	Oscar Health	Yes	Policy
Minnesota	Medica	Yes	Evidence of Coverage
	Group Health/Health Partners	Yes	Benefits Chart
	UCare	Yes	Member Contract
	Blue Plus	Yes	Handbook
	Quartz	No	Confirmed via phone by customer service representative.
Mississippi	Ambetter/Magnolia	Yes	Evidence of Coverage
	Molina	NBPP*	Schedule of Benefits
Missouri	Medica	Yes	Evidence of Coverage
	Ambetter/Celtic (Centene)	Yes	Evidence of Coverage
	Cigna	No	Confirmed via phone by customer service representative.
	Anthem	Yes	Evidence of Coverage
	SSM/WellFirst	No	Confirmed via phone by customer service representative.
	Cox	Yes	Policy
	Oscar	Yes	Evidence of Coverage
	Blue KC	Yes	Website
Montana	BCBS	Yes	Handbook
	Montana Health CO-OP	Yes	Policy
	PacificSource	Yes	Schedule of Benefits
Nebraska	Bright Health	NBPP*	Evidence of Coverage
	Medica	Yes	Evidence of Coverage
Nevada	Health Plan of NV	Yes	Evidence of Coverage
	SilverSummit	Yes	Summary of Benefits and Coverage
	HMO Nevada (HMO Colorado/Anthem)	Yes	Evidence of Coverage
	SelectHealth	Yes	Evidence of Coverage
	Friday	No	Confirmed via phone by customer service representative.
New Hampshire	Ambetter/Celtic	Yes	Evidence of Coverage
	Anthem	Yes	Evidence of Coverage
	Harvard Pilgrim	No	Confirmed via phone by customer service representative.

New Jersey	Oscar	Yes	Confirmed via phone by customer service representative.
	AmeriHealth	No	Confirmed via phone by customer service representative.
	Horizon Healthcare Services (BCBS)	No	Confirmed via phone by customer service representative.
New Mexico	Molina	Yes	Formulary
	Friday	No	Confirmed via phone by customer service representative.
	BCBS	Yes	Handbook
	True Health	Yes	Evidence of Coverage
	Western Sky Community Care (Ambetter/ Centene)	Yes	Evidence of Coverage
New York	Fidelis	No	Member Contract
	Capital District Physicians' Health Plan	No	Confirmed via phone by customer service representative.
	Emblem	No	Confirmed via phone by customer service representative.
	Health Plus HP	No	Evidence of Coverage
	Excellus Health	No	Confirmed via phone by customer service representative.
	Healthfirst PHSP	No	Confirmed via phone by customer service representative.
	HealthNow New York (BCBS of Western NY; Blue Cross of NE NY)	Yes	Confirmed via phone by customer service representative.
	Independent Health Benefit Corporation	Yes	Confirmed via phone by customer service representative.
	Metro Plus Health Plan	No	Plan Contract
	MVP Health Plan	No	Confirmed via phone by customer service representative.
	Oscar	No	Confirmed via phone by customer service representative.
	UnitedHealthcare of NY	Undetermined	Plan documents inaccessible, customer service representative unreachable
North Carolina	BCBS	Yes	Confirmed via phone by customer service representative.
	Cigna	Yes	Evidence of Coverage
	Ambetter	Yes	Evidence of Coverage
	Bright Health	No	Confirmed via phone by customer service representative.
	Oscar	Yes	Policy
	UnitedHealthcare	Yes	Policy
North Dakota	Medica	Yes	Evidence of Coverage
	BCBS	No	Confirmed via phone by customer service representative.
	Sanford	No	Confirmed via phone by customer service representative.
Ohio	Aultcare	Yes	Summary of Benefits and Coverage
	Ambetter	Yes	Evidence of Coverage
	BCBS	Yes	Evidence of Coverage
	CareSource	Yes	Evidence of Coverage
	Medical Mutual	Yes	Confirmed via phone by customer service representative.
	Molina	Yes	Formulary
	Oscar Buckeye State Insurance Corp	Yes	Evidence of Coverage
	Oscar Insurance Corp. of Ohio	Yes	Evidence of Coverage

	Paramount	Yes	Confirmed via email by custom service representative.
	Summa	No	Confirmed via phone by customer service representative.
Oklahoma	BCBS	Yes	Evidence of Coverage
	Bright Health	No	Confirmed via phone by customer service representative.
	Medica	Yes	Evidence of Coverage
	CommunityCare	No	Confirmed via phone by customer service representative.
	Oscar	Yes	Evidence of Coverage
	UnitedHealthcare	Yes	Policy
Oregon	BridgeSpan	Yes	Policy
	Kaiser	No	Confirmed via phone by customer service representative.
	Moda	Yes	Policy
	PacificSource	Yes	Summary of Benefits and Coverage
	Providence	NBPP*	Contract
	Regence	Yes	Policy
Pennsylvania	Capital Advantage Assurance	No	Handbook
	Geisinger Health Plan	Yes	Confirmed via phone by customer service representative.
	Geisinger Quality Options	Yes	Confirmed via phone by customer service representative.
	Highmark, Inc.	No	Confirmed via phone by customer service representative.
	Highmark Benefits Group	No	Confirmed via phone by customer service representative.
	Highmark Coverage Advantage	No	Confirmed via phone by customer service representative.
	Keystone Health Plan East (Independence Blue Cross HMO)	Yes	Handbook
	QCC Insurance Company (Independence Blue Cross PPO)	Yes	Handbook
	UPMC Health Options	No	Confirmed via phone by customer service representative.
	PA Health and Wellness (Ambetter)	Yes	Evidence of Coverage
	Oscar Health	Yes	Evidence of Coverage
Rhode Island	BCBS	Yes	Subscriber Agreement
	Neighborhood Health Plan of RI	No	Confirmed via phone by customer service representative.
South Carolina	BCBS	Yes	Confirmed via phone by customer service representative.
	Ambetter/Absolute Total Care	Yes	Evidence of Coverage
	Bright	No	Confirmed via phone by customer service representative.
	Molina	Yes	Formulary
South Dakota	Avera	Yes	Confirmed via phone by customer service representative.
	Sanford	No	Confirmed via phone by customer service representative.
Tennessee	BCBS	NBPP*	Summary of Benefits and Coverage
	Cigna	No	Confirmed via phone by customer service representative.
	Oscar	Yes	Evidence of Coverage
	Bright	No	Confirmed via phone by customer service representative.

	Ambetter/Celtic	Yes	Confirmed via phone by customer service representative.
	UnitedHealthcare	Yes	Policy
Texas	Celtic/Ambetter	Yes	Confirmed via phone by customer service representative.
	BCBS	Yes	Evidence of Coverage
	CHRISTUS	Yes	Confirmed via phone by customer service representative.
	Molina	Yes	Formulary
	Oscar	Yes	Evidence of Coverage
	Sendero	Yes	Confirmed via phone by customer service representative.
	SHA/FirstCare (acquired by Scott & White)	Yes	Confirmed via phone by customer service representative.
	Community Health Choice	Yes	Evidence of Coverage
	Friday	No	Confirmed via phone by customer service representative.
	Scott & White	Yes	Confirmed via phone by customer service representative.
Utah	Molina	Yes	Formulary
	Regence	Yes	Policy
	SelectHealth	No	Confirmed via phone by customer service representative.
	University of Utah Health Plans	No	Confirmed via phone by customer service representative.
	BridgeSpan	Yes	Policy
	Cigna	No	Confirmed via phone by customer service representative.
Vermont	BCBS of VT	No	Confirmed via phone by customer service representative.
	MVP	Yes	Confirmed via phone by customer service representative.
Virginia	State law in place		
Washington	BridgeSpan Health Company	Yes	Policy
	Coordinated Care Corporation	NBPP*	Evidence of Coverage
	Kaiser Foundation Health Plan of the NW	No	Confirmed via phone by customer service representative.
	Kaiser Foundation Health Plan of Washington	No	Confirmed via phone by customer service representative.
	LifeWise Health Plan of Washington	No	Confirmed via phone by customer service representative.
	Molina Healthcare of Washington	NBPP*	Summary of Benefits and Coverage
	PacificSource Health Plans	Yes	Summary of Benefits and Coverage
	Premera Blue Cross	No	Confirmed via phone by customer service representative.
	Providence Health Plan	NBPP*	Individual Contract
	Community Health Network of WA	Yes	Confirmed via phone by customer service representative.
	Regence BCBS	Yes	Policy
	Regence BS	Yes	Policy
	UnitedHealthcare	Yes	Policy
West Virginia	State law in place		
Wisconsin	Molina	Yes	Summary of Benefits and Coverage
	Network Health	No	Confirmed via phone by customer service representative.

Wisconsin	Quartz Health Benefits	No	Confirmed via phone by customer service representative.
	Security Health Plan of Wisconsin	Yes	Policy
	WPS (Arise Health Plan)	Yes	Confirmed via phone by customer service representative.
	Aspirus Health Plan	Undetermined	
	Common Ground Healthcare Cooperative	Yes	Evidence of Coverage
	Children's Community Health Plan	Yes	Confirmed via phone by customer service representative.
	Dean Health Plan	Yes	Confirmed via phone by customer service representative.
	Group Health Cooperative of South Central WI	No	Confirmed via phone by customer service representative.
	Medica Health Plans of WI	Yes	Evidence of Coverage
	MercyCare HMO	Yes	Confirmed via phone by customer service representative.
	HealthPartners	Yes	Benefits Chart
	Anthem BCBS	Yes	Evidence of Coverage
Wyoming	BCBS	No	Confirmed via phone by customer service representative.
	Mountain Health CO-OP	Yes	Plan Policy

*Policy aligns with the HHS 2020 Notice of Benefit and Payment Parameters, whereby copay assistance conts toward the patient's out-of-pocket costs for a brand drug if no generic equivalent is available. For the purpose of this report, NBPP is counted as "Yes," the insurer has a copay accumulator policy.

THE AIDS INSTITUTE

National Policy Office
1627 "Eye" Street NW, Suite 835
Washington, DC 20006
Phone: 202-835-8373

Program and
Administrative Office
17 Davis Boulevard, Suite 403
Tampa, FL 33606
Phone: 813-258-5929
Fax: 888-714-7243

aidsinstitute.net

Published March 2021