OFFICE OF LEGISLATIVE RESEARCH
Objective Research for Connecticut's Legislature

ResearchReport

Copay Accumulator Programs

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Issue

This report (1) identifies the U.S. jurisdictions that ban or restrict the use of copay accumulator programs, (2) describes Connecticut's related laws and federal legislation and litigation, and (3) provides information on the prevalence of copay accumulator programs in the United States. It also briefly discusses copay maximizer programs. It updates, in relevant part, OLR Report 2022-R-0037.

The Office of Legislative Research is not authorized to give legal opinions and this report should not be considered one.

Summary

Some health insurers and pharmacy benefit managers (PBM) use copay accumulator programs to calculate an insured patient's cost-sharing responsibility (e.g., deductible, copay, coinsurance, out-of-pocket maximum). Under copay accumulator programs, drug manufacturer coupons and copay assistance generally do not apply toward a patient's cost-sharing responsibility. Without these programs, if a patient uses a coupon or copay assistance, the insurer or PBM generally counts the coupon or assistance amount toward the patient's cost-sharing responsibility. Most research indicates that these programs are becoming more prevalent in the United States.

Federal law allows states to prohibit copay accumulator programs, and many have. As of January 2024, 20 states, the District of Columbia, and Puerto Rico have laws that ban or restrict a health insurer's or PBM's use of copay accumulator programs. Additionally, recent federal litigation appears to restrict the use of most copay accumulator programs; however, the relevant federal agencies have not yet issued a final rule.

Copay Accumulator Prohibitions

Table 1 lists the 22 U.S. jurisdictions that ban or restrict insurers' or PBMs' use of copay accumulator programs. These laws generally require that when calculating an enrollee's cost-sharing amount, they must include amounts paid on the enrollee's behalf by third parties.

Table 1: Laws in U.S. Jurisdictions on Copay Accumulator Programs (January 2024)

Arizona Ariz. Rev. Stat. Ann. § 20-1126	**Nebraska** Neb. Rev. Stat. § 44-4606(5)
Arkansas Ark. Code. Ann. § 23-79-2303	**New Mexico** N.M. Stat. Ann. § 59A-22-53.3
Colorado Colo. Rev. Stat. § 10-16-161	**New York** N.Y. Ins. Law § 3216(i)(37)
Connecticut CGS §§ 38a-477ff, -477gg & -478w	**North Carolina** N.C. Gen. Stat. § 58-56A-3(c1)
Delaware Del. Code tit. 18 § 3382A	**Oklahoma** Okla. Stat. tit. 36, § 1250.5 (18)
District of Columbia D.C. Law 25-26 (2023)	**Puerto Rico** Laws of P.R. 26 § 4.070(B)
Georgia Ga. Code Ann. § 33-64-10(e)	**Tennessee** Tenn. Code Ann. § 56-7-3205
Illinois 215 Ill. Comp. Stat. Ann. § 134/30(d)	**Texas** Tex. Gov. Code § 1369.0542
Kentucky Ky. Rev. Stat. Ann. § 304.17A-164	**Virginia** Va. Code Ann. § 38.2-3407.20
Louisiana La. Stat. Ann. § 22:976.1	**Washington** Wash. Rev. Code § 48.43.435
Maine Me. Rev. Stat. Ann. tit. 24A § 4349(6)	**West Virginia** W. Va. Code §§ 33-15-4t, 33-16-3ee & 33-25A-8t

Source: NCSL

Connecticut Law

In Connecticut, state law requires certain health carriers (e.g., insurers, HMOs, and managed care organizations) and PBMs, when calculating a covered individual's cost sharing liability for a covered benefit, to credit discounts provided and payments made by a third party for any portion of the cost sharing. Thus, it prohibits copay accumulator programs. The requirements are codified at CGS §§ 38a-477ff, -477gg & -478w.

CGS § 38a-477ff applies to each insurer, hospital or medical service corporation, HMO, or fraternal benefit society that delivers, issues, renews, amends, or continues in Connecticut on or after January 1, 2022, certain individual or group health insurance policies. The law applies to policies that that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; or (4) hospital or medical services, including those provided under an HMO plan (i.e., those specified in CGS § 38a-469(1), (2), (4), (11) & (12)). The Connecticut Insurance Department (CID) points out that CGS § 38a-477ff does not apply to policies that provide only single service ancillary health coverage such as dental, vision, or prescription drug coverage, as considered in CGS § 38a-469(16).

The other two other statutory provisions generally prohibit the use of copay accumulator programs in contracts between certain healthcare entities. CGS § 38a-478gg applies to contracts entered into between a health carrier and a PBM on and after January 1, 2022. CGS § 38a-478w applies to managed care organizations that deliver, issue, renew, amend, or continue contracts in Connecticut on or after January 1, 2022. (Note that these statutes do apply to ancillary health coverage, according to CID.)

Lastly, all three of these statutes apply to high deductible health plans (HDHP) to the maximum extent permitted by federal law. They also apply to HDHPs that are used to establish a health savings account, medical savings account (MSA), or Archer MSA to the maximum extent permitted by federal law and without disqualifying the insured from receiving the associated federal tax benefits.

However, due to the federal Employee Retirement Income Security Act (ERISA), these statutes generally do not apply to self-insured benefit plans. For more information on ERISA preemption, see OLR Report 2020-R-0214.

Federal Legislation and Litigation

Legislation

In terms of federal activity, Congressional representatives introduced the Help Ensure Lower Patient (HELP) Copays Act (H.R. 5801) in the House of Representatives in November 2021. The bill, which did not pass, would have prohibited the use of copay accumulator programs by requiring that the value of third-party payments, financial assistance, discounts, product vouchers, and other reductions in out-of-pocket expenses count toward an enrollee's cost-sharing limit. According to proponents, the bill was intended to reverse a federal "2021 rule" that allowed copay accumulator programs to the extent permitted under state law (45 C.F.R. § 156.130(h)). In the current biennial

session (2023-2024), legislators reintroduced the HELP Copays Act (H.R. 830 and S. 1375). These most recent versions of the bill are pending.

Litigation

In 2022, three individuals and three patient advocacy groups filed a lawsuit in district court against the U.S. Department of Health and Human Services (HHS) and the Centers for Medicare and Medicaid Services to challenge the 2021 rule that generally allowed the use of copay accumulator programs. They argued that the rule violates the Affordable Care Act's (ACA) definition of cost sharing as well as prior regulatory guidance. On September 29, 2023, the court granted the plaintiffs' motion for summary judgment, vacated the challenged rule, and remanded the matter to the agencies (*HIV and Hepatitis Policy Institute v. U.S. Dept. of Health and Human Services et al,* Civ. A. No. 22-2604 (JDB), 2023 WL 6388932 (D.D.C. Sept. 29, 2023)).

In November 2023, the agencies asked the court to clarify the scope of its order. In December 2023, the court clarified that the rule in place prior to adoption of the 2021 rule was reinstated (known as the 2020 rule, previously codified at 45 C.F.R. § 156.130(h) from June 24, 2019, to July 12, 2020). The 2020 rule requires copay assistance to count as patient cost sharing for prescription drugs, except for brand name drugs with generic equivalents (*HIV and Hepatitis Policy Institute* v. *U.S. Dept. of Health and Human Services et al,* Civ. A. No. 22-2604 (JDB), (D.D.C. Dec. 22, 2023)).

HHS, in its motion to clarify, said it intends to enact another rule on this subject, but has not yet.

Prevalence of Copay Accumulator Programs

Several recent studies have estimated the prevalence of copay accumulator programs in the United States. While the estimates vary by study, there is general agreement that the usage and application of these programs have been increasing in recent years and will continue to do so.

A study published in September 2023 in the Journal of Market Access and Health Policy estimated that the prevalence of insurance plans with copay accumulator programs increased from 44% to 80% from 2018 to 2021, with approximately 43% of insured patients subject to one. The study (1) noted that insurance companies are not required to disclose their use of copay accumulator programs and (2) found that patients were generally unaware of the programs and suspected that adding them to an insurance plan would raise out-of-pocket costs considerably.

Drug Channels, an organization that provides research into pharmaceutical economics and the drug distribution system, released a study in February 2023 that said that about 40% of

commercially insured individuals were subject to copay accumulator programs in 2022. IVQIA, a healthcare innovation and technology company, reported in a December 2022 study that the prevalence of these programs increased from 14% of commercially insured patients in 2019 to 33% in 2022.

Lastly, a December 2023 article estimates that "about 81% of people covered by 35 insurers and PBMs representing 117.8 million lives were enrolled in plans with copay accumulators as of September 2023, compared with 89% in 2022, according to data collected by…MMIT." MMIT, also known as Managed Markets Insight & Technology, LLC, employs pharmacists, clinicians, data specialists, and market researchers who seek to provide insight into pharmaceutical therapies and identify barriers to patient access. The article also states that insurance payers "anticipated a 30% increase in the number of plan sponsors opting into such programs [in 2024] and a 14% increase in member enrollment in plans [using these programs]."

Copay Maximizer Programs

Some insurers and PBMs have adopted copay maximizer programs instead of copay accumulator programs. While copay accumulator programs prevent third-party copay assistance from counting towards an insured patient's cost sharing requirements, copay maximizers distribute the total assistance amount over 12 months, making that amount the patient's new monthly copayment on any covered drug over the course of a year.

Most state copay accumulator bans appear to also ban copay maximizer programs (e.g., they require third-party payments to apply towards cost-sharing requirements). However, some of the state laws cited above that restrict the use of copay accumulator programs have exclusions allowing insurers to use the programs for certain drugs such as brand name drugs with generic equivalents and drugs not considered medically necessary. According to some of the studies described above (e.g., Drug Channels and MMIT), some insurers using copay maximizer programs are (1) using these statutory exceptions or (2) deeming certain specialty prescription drugs to be "non-essential" health benefits, thus subjecting them to higher cost-sharing requirements beyond what the ACA requires for essential health benefits.

Connecticut's state law banning copay accumulator programs does not have the statutory exceptions described above, thus it appears to prohibit copay maximizer programs as well. Further, based on input from CID, we were unable to find evidence of if insurers operating in Connecticut are deeming certain drugs to be non-essential benefits.

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