Copay accumulator adjustment programs:

A new kind of sticker shock

Introduction

Health insurance plan designs are a constantly evolving constellation of incentives and disincentives that impact the healthcare choices made by patients and their healthcare providers. These can include incentives to partake in wellness programs as well as disincentives to use out of network providers. As patients are made aware of these plan rules they can decide for themselves the degree to which they will comply in order to save money, balancing savings with convenience and even health outcomes.

A new disincentive is now being incorporated into some health plan contracts, and this one has a twist. Unlike typical disincentives that are clearly publicized, patients who are governed by this new disincentive may not even know it exists until they experience unexpected out of pocket (OOP) costs for their medications. It is the "accumulator adjustment program."

What exactly is a health plan accumulator adjustment program?

One of the tasks performed by Pharmacy Benefit Managers (PBMs) is to monitor the contributions patients make toward fulfilling their annual deductibles and OOP maximums. Standard accumulators serve an important purpose: they track patients' payments, and once a patient has met their deductible the health plan begins to pay for services according to the plan design. (Of course, even at that point, patients still pay for part of their care via copay or coinsurance until they have reached their maximum annual OOP amount, after which insurance pays all covered costs.)

Certain health plans are now asserting the right to determine which payments count toward fulfilling a patient's deductible based on which entity is making the payment. Specifically, for certain medications in some plans, the insurance plan may not allow the dollar value of a manufacturer's copay support to count toward the patient's deductible. Table 1 (below) identifies several of the major accumulator adjustment programs.

What types of accumulator adjustment programs are being used?

There are a number of accumulator adjustment approaches that have been put forward by PBMs and health plans. The most common type in use today is the standard (true) accumulator adjustment. This entails a claims analysis that identifies the source of funds for drug claim payments and ensures that only the amount a member personally pays is counted toward their deductible. In some cases, this judgment is made in close to real time; in other cases, the adjustment can come days or weeks after the medication has been acquired. At full potential, this can mean that patients may have no idea how much a therapy will really cost them until well after they take the medication. This could result in a new kind of sticker shock.

How do PBMs know that a particular payment has been made by a manufacturer copay program rather than by the patient herself?

PBMs do not have direct visibility into the secondary pharmacy claims that are created every time a traditional coordination of benefits copay offer is processed by a pharmacy. Instead, PBMs gain visibility to copay program payments via pharmacies owned or controlled by the PBM (see Table 1) or through other contractual arrangements with pharmacies.

Table 1: Major accumulator adjustment programs

PBM	Specialty pharmacy	Program name
CVS Caremark	CVS Specialty	CVS Specialty Co-Pay Card Program – "True Accumulator"
Express Scripts	Accredo	Out-of-Pocket Protection Program
Prime Therapeutics	allianceRx (Walgreens + Prime)	Prime's Specialty Co-Pay Solutions
United Healthcare / Optum	BriovaRx	Coupon Adjustment: Benefit Plan Protection Program

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How do accumulator adjustment programs impact patients?

To understand the negative consequences this can have on a patient's finances, it is helpful to review a simple comparison of the "non-accumulator adjustment" and "accumulator adjustment" scenarios.

In a non-accumulator adjustment scenario, the dollars paid by a manufacturer sponsored copay program are applied to the patient's deductible requirements, so that by the time a patient has exhausted the copay program benefits, their insurance deductible is likely to have been fully met; as a result, going forward insurance covers the bulk of the cost of the medication while the patient pays the copay or coinsurance amount.

In an accumulator adjustment scenario, on the other hand, the dollars paid by a manufacturer sponsored copay program are NOT applied to the patient's deductible requirements, so that when a patient has exhausted the copay program benefits, there may still be a large portion of the insurance deductible remaining to be paid; as a result, insurance covers none of the cost of the medication, leaving the patient responsible to pay the entire cost until the patient meets the deductible using their own funds. See an example of the accumulator adjustment scenario in Table 2.

Why does this matter?

This issue is crucially important because high patient OOP medication costs are highly correlated with poor adherence generally and prescription abandonment in particular. Recent research suggests that patients with drug deductibles are 3 times more likely to abandon a prescription[1]:

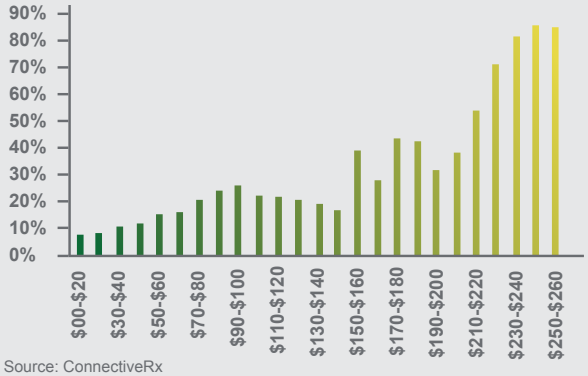
No drug deductible: 9% abandonment

Brand with a deductible: 23% abandonment

Specialty brand with deductible: 27% abandonment

One of the ways to assess prescription abandonment is by measuring "brand reversals," which essentially refers to prescriptions received at a pharmacy but never picked up. A leading cause of brand reversals are prescriptions rejected by patients because of high OOP costs. As an example, Figure 1 (below) is based on a recent ConnectiveRx examination of the reversal rates for ADHD copay claims for patients less than 18 years of age. The reversal rate hit 16% at a copay of $50 to $60 and 26% at $90 to $100. At a copay of $150 and higher, reversal rates are typically 40% or above.

Figure 1: ADHD Class reversal rate by patient OOP (Q3 2015-Q3 2017)



Source: ConnectiveRx

Why is this particularly difficult from a patient point of view?

A recent survey showed that only 9% of consumers demonstrated an understanding of four basic health insurance terms (health plan premium, health plan deductible, OOP maximum and coinsurance). Now, along comes an entirely new concept, accumulator adjustment programs, that are being put into place with little advance notice. It is likely that few consumers will fully understand what these programs are or how they could impact the support they are receiving from pharmaceutical manufacturers. As a result, patients are left to be surprised when months and months go by and they find that they are no closer to meeting their deductible.

Which patients will be impacted?

Patients with chronic conditions who are using complex biologics are at the front line of this issue. These brands frequently provide patient financial support for patients to help them through their

Table 2: Accumulator adjustment scenario*

Month	Drug cost	Insurance pays	Copay program pays	Patient pays	Applied to deductible
1	$3,000	$0	$3,000	$0	$0
2	$3,000	$0	$3,000	$0	$0
3	$3,000	$0	$3,000	$0	$0
4	$3,000	$0	$3,000	$0	$0
5	$3,000	$0	$3,000	$0	$0
6	$3,000	$0	$0 (Program cap reached)	Patient owes $3,000, creating potential adherence failure	
Totals	$15,000	$0	$15,000	$0	$0

* Assumptions: $3,000 monthly drug cost, $5,000 deductible, PNMT $0 copay offer with $15,000 annual cap

deductible periods. Unless the brand pays the full amount of therapy with no cap, the patient may not reach their deductible. In some cases, this could result in the health plan paying nothing for a covered drug for the entire year, leaving the patient responsible to pick up the tab after the copay program has been exhausted. For many patients, that level of financial burden is simply not sustainable.

A recent ConnectiveRx analysis of patients using copay cards for specialty medications suggests that in 1Q 2018, approximately 4% to 8% of copay patients using manufacturer support programs were being impacted by accumulator adjustment programs. However, it is clear that these programs are a high priority for PBMs and health plans. One industry observer estimates that by the end of 2018, 50% of self insured employer plans will be employing accumulator adjustment programs.[2]

How do I know how my brand will be impacted?

ConnectiveRx can evaluate a brand's copay claims to identify potential causes of high patient benefit costs. There can be a number of causes of these costly claims (including accumulator adjustment programs, pharmacy misprocessing and high deductible plans) so it is important to determine the specific cause.

What are other stakeholders saying about accumulator adjustment programs?

These programs are stimulating strong responses from many quarters, including industry observers, experts and patient advocacy groups:

Industry observers and experts:

Adam Fein, PhD, of Drug Channels: *Copay Accumulators: Costly Consequences of a New Cost-Shifting Pharmacy Benefit*

Dr. Yanira Cruz, president and CEO of the National Hispanic Council on Aging: *Middlemen Threaten Patient Access With Accumulator Adjustment Programs*

Ed Silverman, of Pharmalot: *Which drug makers are most vulnerable to a new cost-shifting maneuver?*

Patient advocacy groups:

Arthritis Foundation: *TAKE CARE: Advocacy Blog Series — Accumulator Adjustment Programs*

Diabetes Patient Advocacy Coalition: *Accumulator Adjustment Programs Put Added Burden On People with Diabetes*

Institute for Patient Access: *Patients' Nasty Co-pay Surprise*

PhRMA: *Let's Talk About Cost*

How can brands continue to help patients afford their medications?

The ConnectiveRx team works closely with manufacturers to estimate their exposure to accumulator adjustment programs, and develop and execute solutions that help patients get and stay on their prescribed medications.

Put simply, we recommend four basic steps:

1. Educate your patients regarding accumulator adjustment programs to help them identify whether or not they are being affected
2. Assess and monitor the extent to which accumulator adjustment programs are impacting your patients overall and your costs
3. Consider ways to enhance your copay program
4. Contact ConnectiveRx to learn more

For more information, please visit ConnectiveRx.com

References:

1. IQVIA Institue for Human Data Science. *Medicines Use and Spending in the U.S.* May 2017. Accessed June 5, 2018.
2. Silverman E. *Which drug makers are most vulnerable to a new cost-shifting maneuver?* STAT. April 18, 2018. Accessed June 5, 2018.