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Faced with High Cost Sharing for Brand Medicines, Many Commercially Insured Patients with Chronic Conditions Use Manufacturer Copay Assistance

FEBRUARY 2023

Executive Summary

Out-of-pocket spending for prescription medicines a decade ago consisted almost entirely of copays, but use of deductibles and coinsurance in commercial health insurance has skyrocketed in recent years.[1] This shift has resulted in many patients with chronic conditions being asked to pay a larger share of the cost of their medicines.

> ***Faced with high costs at the pharmacy counter, a growing share of commercially insured patients rely on copay assistance programs offered by pharmaceutical manufacturers to help them pay their out-of-pocket costs.[1]***

IQVIA analyzed changes in out-of-pocket spending among commercially insured patients between 2017 and 2021. The study includes patients taking brand medicines across six therapy areas: anticoagulants, respiratory conditions, depression, diabetes, human immunodeficiency virus (HIV) and oncology. To assess the impact of manufacturer copay assistance programs on out-of-pocket cost trends, IQVIA analyzed changes in patients' final out-of-pocket spending as well as changes in their out-of-pocket cost exposure, which is the out-of-pocket cost set by their health plan and pharmacy benefit managers (PBMs) before any copay assistance is used. The findings show that:

1. Deductibles and coinsurance drive high out-of-pocket costs for patients.
2. Health plans and PBMs expose patients taking brand medicines to high costs at the pharmacy counter.
3. Copay assistance programs can significantly improve affordability for patients.

1. DEDUCTIBLES AND COINSURANCE DRIVE HIGH OUT-OF-POCKET COSTS FOR PATIENTS.

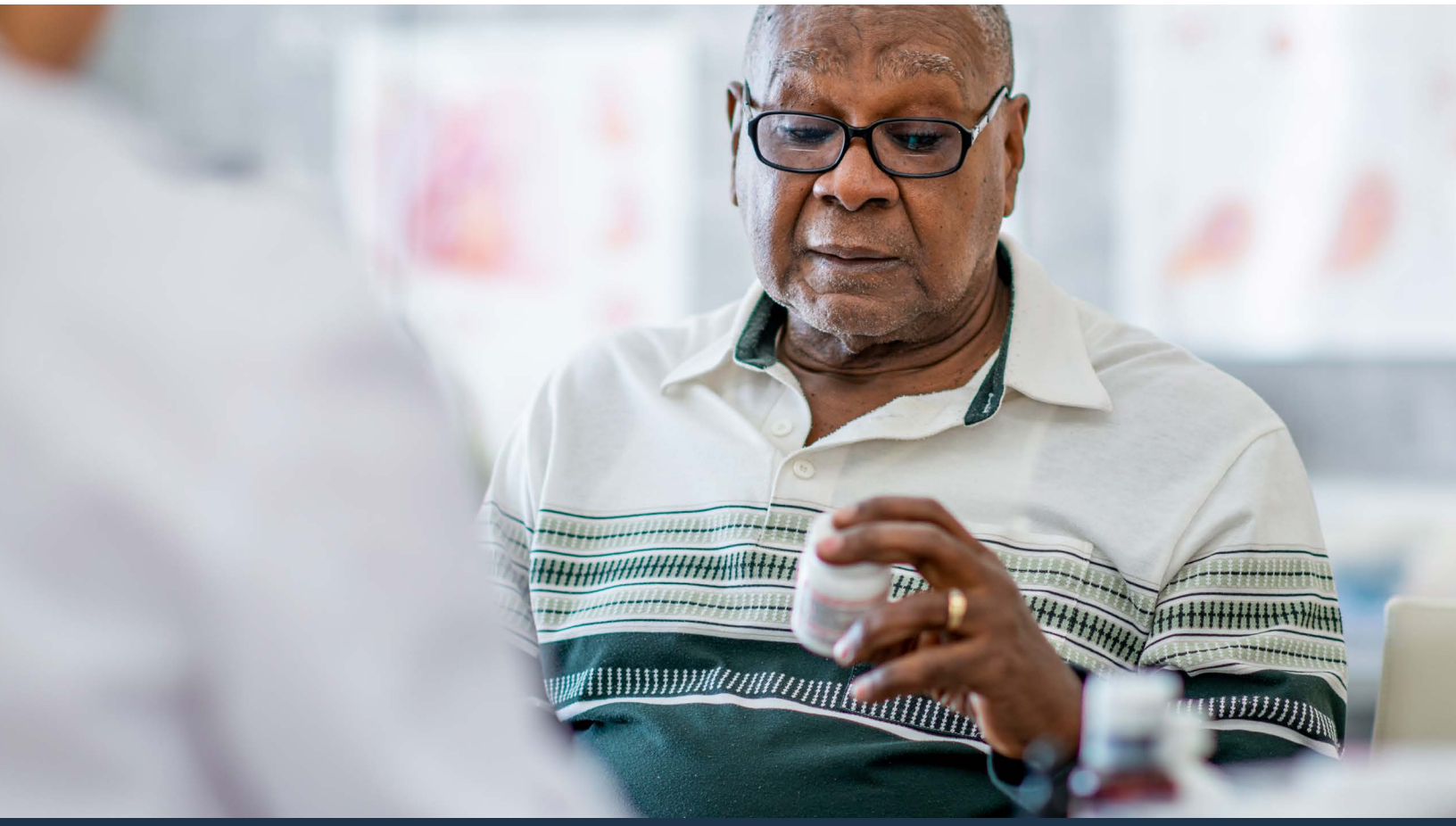
- **Out-of-pocket costs are significantly higher among patients with deductibles and coinsurance relative to those with copays.** For example, patients who filled prescriptions for brand oncology medicines in the deductible or with coinsurance paid nearly 10 times more out of pocket for their prescription medicines in 2021 compared to patients with copay-only cost sharing.
- **Medicines subject to a deductible or filled using coinsurance account for a significant share of total patient out-of-pocket spending on brand medicines.** Combined, deductible and coinsurance spending account for more than half of patients' total out-of-pocket spending on brand medicines for four of the six therapy areas examined.
- **Total patient out-of-pocket spending on brand medicines is concentrated among prescriptions subject to deductibles or coinsurance.** For example, just 13% of brand oncology prescriptions are filled in the deductible or with coinsurance, but these prescriptions account for 93% of total patient out-of-pocket spending on brand oncology medicines.

2. HEALTH PLANS AND PBMS EXPOSE PATIENTS TAKING BRAND MEDICINES TO HIGH COSTS AT THE PHARMACY COUNTER.

- **Health plans and PBMs are increasingly setting high cost sharing for many brand prescriptions to treat complex and chronic conditions.** In 2021, health plans and PBMs set cost sharing at $125 or greater for more than one in seven brand prescriptions to treat depression and cancer, one in six anticoagulant prescriptions, and one in five HIV prescriptions.
- **Health plans and PBMs use of deductibles and coinsurance exposes patients to high out-of-pocket costs.** For example, patients with coinsurance or deductibles taking brand HIV medicines were exposed to total annual costs for their medicines that were 10 times greater than those faced by patients with only copays.
- **The difference between the amount health plans and PBMs require patients with deductibles and coinsurance to pay compared to the amount patients with copays are expected to pay is growing.** For example, between 2017 and 2021, annual out-of-pocket cost exposure among patients taking brand HIV medicines who were subject to deductibles or coinsurance increased 21% while annual out-of-pocket exposure among patients with copay-only cost sharing declined by 6%.

3. COPAY ASSISTANCE PROGRAMS CAN SIGNIFICANTLY IMPROVE AFFORDABILITY FOR PATIENTS.

- **Many patients with complex and chronic conditions use copay assistance programs offered by pharmaceutical manufacturers.** In 2021, the share of patients using copay assistance to fill one or more brand prescriptions ranged from 6% for respiratory conditions to 53% for HIV.
- **Copay assistance has helped to mitigate the impact of increasing cost sharing set by health plans and PBMs.** In the absence of copay assistance, patients taking brand medicines to treat complex and chronic conditions would have experienced significant growth in out-of-pocket costs. Copay assistance offset this growth and shielded patients from higher costs set by health plans and PBMs.
- **Without manufacturer copay assistance programs, patients would likely pay significantly more out of pocket.** Among patients using copay assistance to access their medicines, patients taking HIV or oncology brand medicines saved more than $1,700 in avoided out-of-pocket spending in 2021.



Background

Commercially insured patients pay cost sharing for prescription medicines through deductibles, copays and coinsurance. When a patient fills a prescription in for the deductible, the patient pays the full undiscounted list price of the medicine until the amount of the deductible is reached. Patients with copays pay a fixed amount for each prescription (e.g., $20), while those with coinsurance typically pay a percentage of the medicine's undiscounted list price (e.g., 20%). A decade ago, out-of-pocket spending for prescription medicines consisted almost entirely of copays. But in recent years, use of deductibles and coinsurance in commercial health insurance has skyrocketed.

> ***Deductibles and coinsurance accounted for 60% of commercially insured patients' out-of-pocket spending on brand medicines in 2021.[2]***

Health plans and pharmacy benefit managers (PBMs) commonly negotiate substantial discounts and rebates on brand medicines, but in most cases, these discounted prices are not made available to patients. Instead, health plans and PBMs typically require patients with deductibles or coinsurance to pay cost sharing based on a medicine's full undiscounted price. In 2021, pharmaceutical manufacturers paid more than $236 billion in rebates, discounts and other payments to health plans, the government and other entities.[3] On average, the net price of brand medicines is 49% lower than the list price.[4]

Because health plans and PBMs typically do not factor in these savings when calculating the deductible and coinsurance amounts that patients must pay, out-of-pocket costs for these patients can be significantly higher than they otherwise would be if based on the discounted cost of the medicine. Notably, this dynamic is unique to prescription medicines, and to brand medicines in particular. In most cases, health plans do factor in negotiated savings when calculating patient costs for in-network medical services like physician or hospital visits.

The following analysis examines trends in total out-of-pocket spending on brand and generic prescription medicines between 2017 and 2021 for commercially insured patients taking at least one brand medicine across six therapy areas: anticoagulants, respiratory conditions, depression, diabetes, human immunodeficiency virus (HIV) and oncology. Findings reflect the average out-of-pocket cost or spending on brand and generic medicines, unless otherwise specified. For brevity, some findings are presented for selected therapy areas only. Complete data for all six therapy areas are included in the appendix.

Results

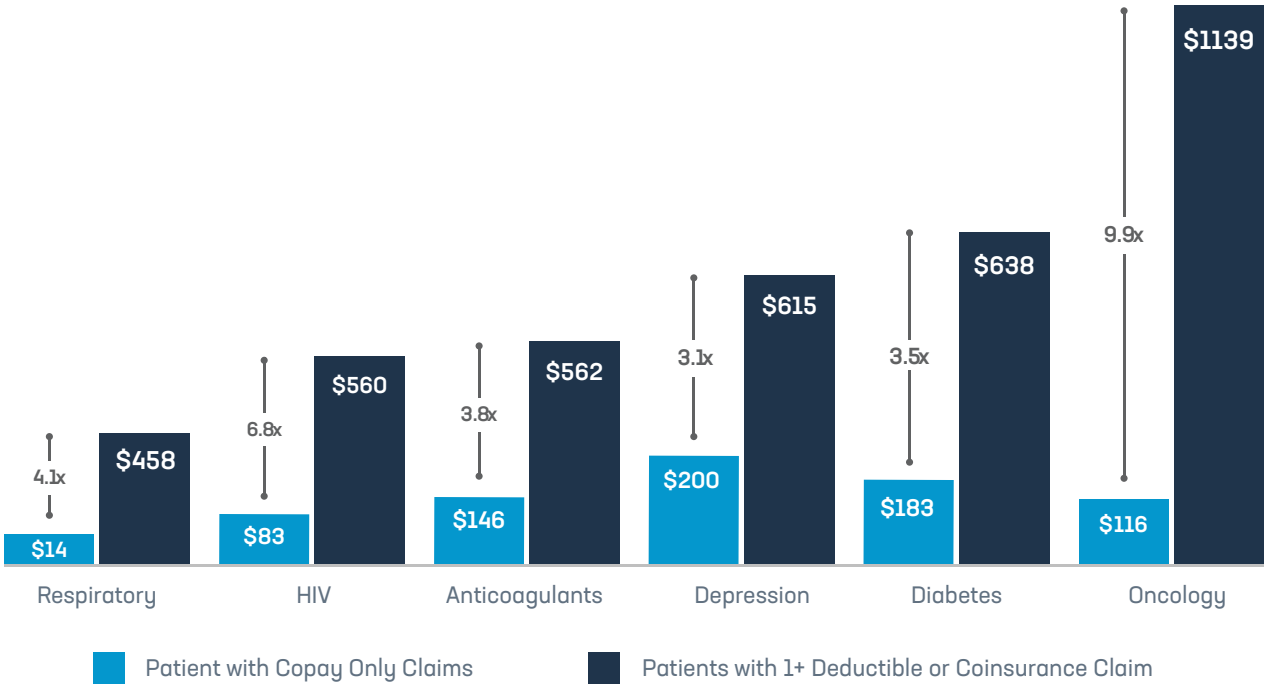
1. DEDUCTIBLES AND COINSURANCE DRIVE HIGH OUT-OF-POCKET COSTS FOR PATIENTS.

Out-of-pocket costs are significantly higher among patients with deductibles and coinsurance relative to those with copays.

Across all six therapy areas, patients subject to deductibles and coinsurance paid significantly more out of pocket per year for their prescription medicines than patients whose only form of cost sharing was copays. In 2021, differences ranged from patients with deductibles or coinsurance taking brand depression medicines paying more than three times as much out of pocket to patients taking brand oncology medicines paying nearly 10 times more out of pocket than patients with copay-only cost sharing.

Research shows that prescriptions with higher out-of-pocket costs are more likely to be abandoned by patients at the pharmacy counter (see Box 1) and medication non-adherence can result in worse health outcomes and higher overall costs down the road.[5]

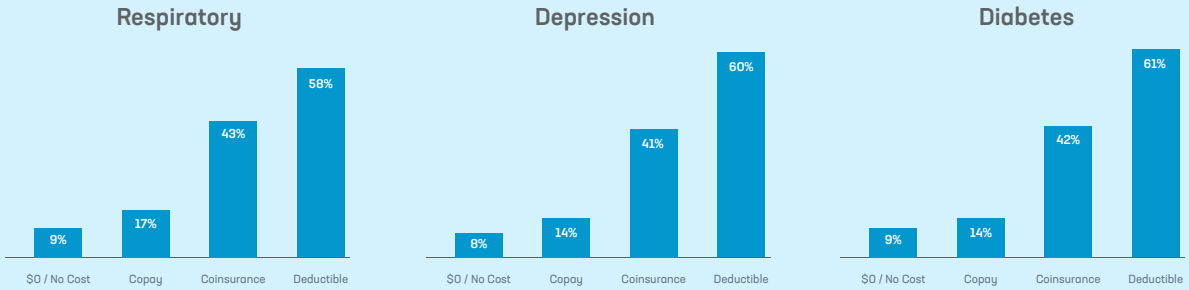
Figure 1: Average Annual Out-of-Pocket Spending by Patients Taking Brand Medicines by Type of Cost Sharing, 2021



Note: Figures represent average annual out-of-pocket spending for commercially insured patients taking condition-specific brand medicine(s). Annual out-of-pocket spending includes both condition-specific and non-condition specific brand and generic medicines.

Box 1: New brand prescriptions filled in the deductible or with coinsurance are more likely to be abandoned at the pharmacy counter than those filled with copay only cost sharing.

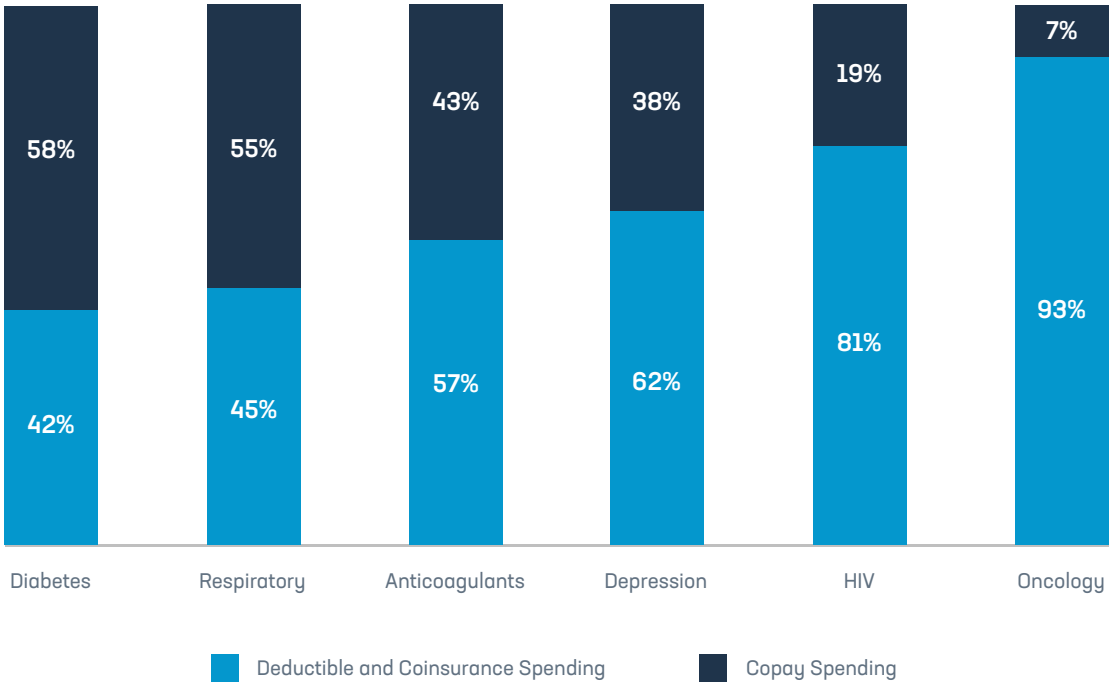
Rate of Abandonment for Newly Prescribed Brand Medicines by Type of Cost Sharing, 2021



Medicines subject to a deductible or filled using coinsurance account for a significant share of total patient out-of-pocket spending on brand medicines.

Patients taking brand medicines pay a substantial share of their out-of-pocket spending for brand medicines in the form of deductibles and coinsurance. For four of the six therapy areas, deductible and coinsurance spending represented more than half of the total amount patients spent out of pocket on brand medicines in 2021. Deductible and coinsurance spending accounted for 81% and 93% of total patient out-of-pocket spending on brand HIV and oncology medicines, respectively.

Figure 2: Share of Final Patient Out-of-Pocket Spending for Brand Medicines by Type of Cost Sharing, 2021

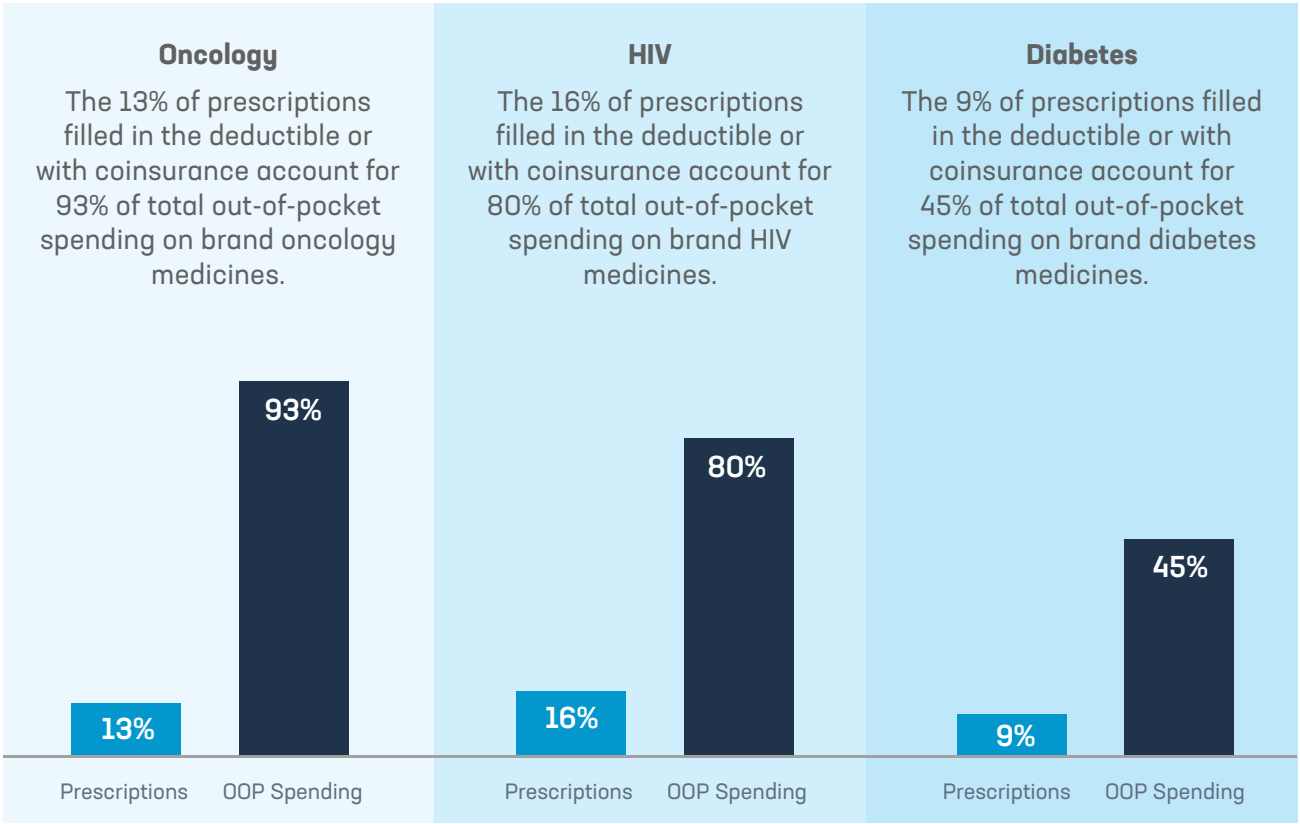


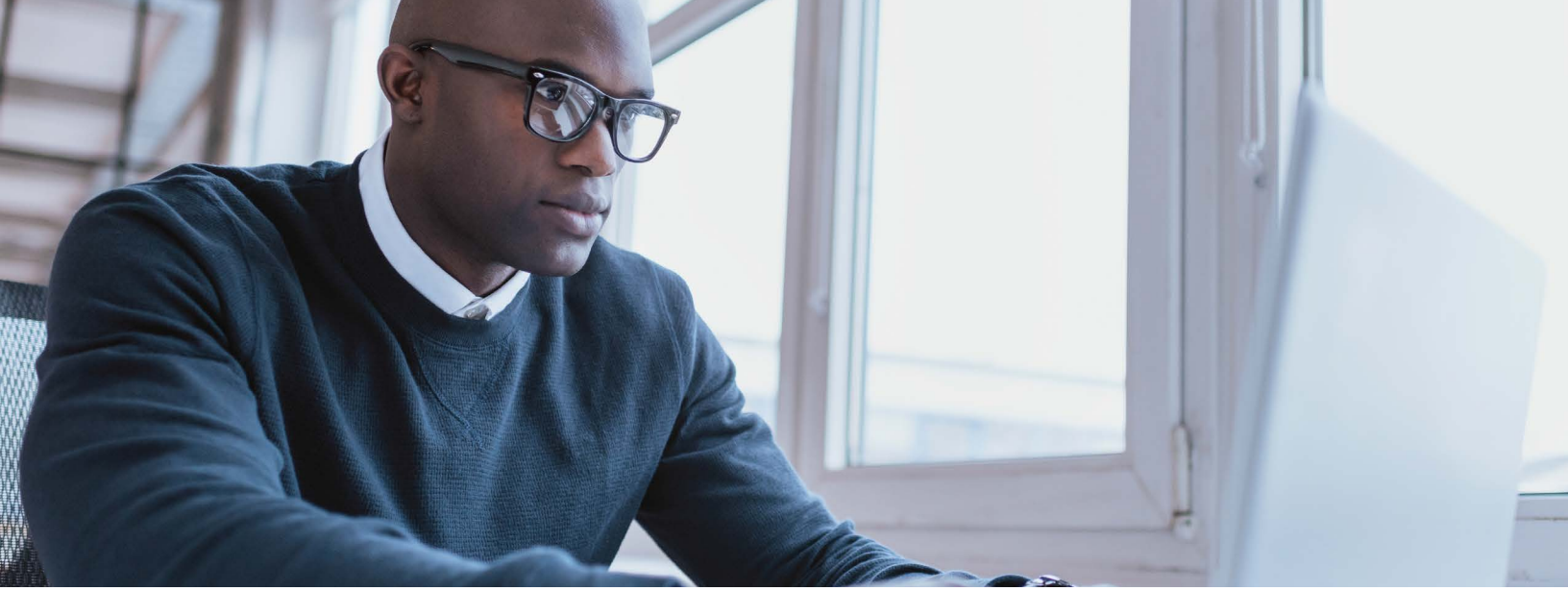
Total patient out-of-pocket costs for brand medicines are concentrated among prescriptions subject to deductibles or coinsurance.

Across all six therapy areas, prescriptions filled in the deductible or with coinsurance accounted for less than a quarter of all brand prescriptions filled in 2021. However, across all six therapy areas, these prescriptions accounted for an outsized share of total patient out-of-pocket spending.

For example, just 13% of brand oncology prescriptions are subject to deductibles or coinsurance, but these fills accounted for 93% of total patient out-of-pocket spending on brand oncology medicines. Similarly, fewer than one in ten (9%) brand diabetes prescriptions were filled in the deductible or with coinsurance, yet these prescriptions accounted for 45% of total patient out-of-pocket spending on these medicines.

Figure 3: Share of Brand Prescriptions Subject to Deductibles or Coinsurance and Share of Total Brand Medicine Out-of-Pocket (OOP) Spending Attributable to These Prescriptions, 2021



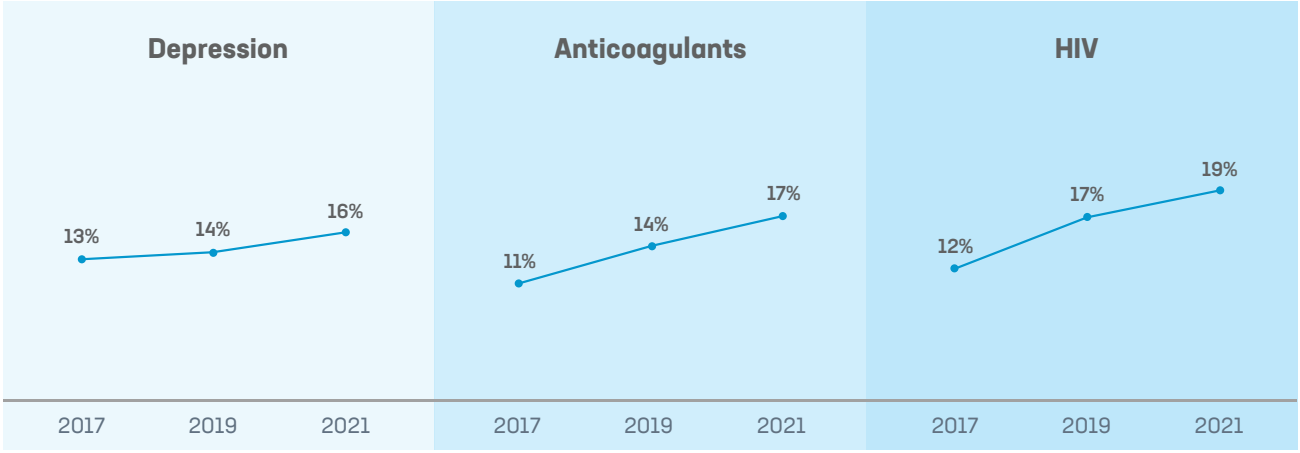


2. HEALTH PLANS AND PBMs EXPOSE PATIENTS TAKING BRAND MEDICINES TO HIGH COSTS AT THE PHARMACY COUNTER.

Health plans and PBMs are increasingly setting high cost sharing for many brand prescriptions to treat complex and chronic conditions.

Patient cost exposure is defined as the amount of cost sharing set by health plans and PBMs and represents what patients would have had to pay out of pocket if manufacturer-provided copay assistance had not been available. In 2021, patient cost exposure for brand medicines was at least $125 for more than one in seven brand prescriptions to treat depression and cancer, one in six anticoagulant prescriptions, and one in five HIV prescriptions. Between 2017 and 2021, the share of prescriptions for which health plans and PBMs required cost sharing of $125 or more increased for five of the six conditions.

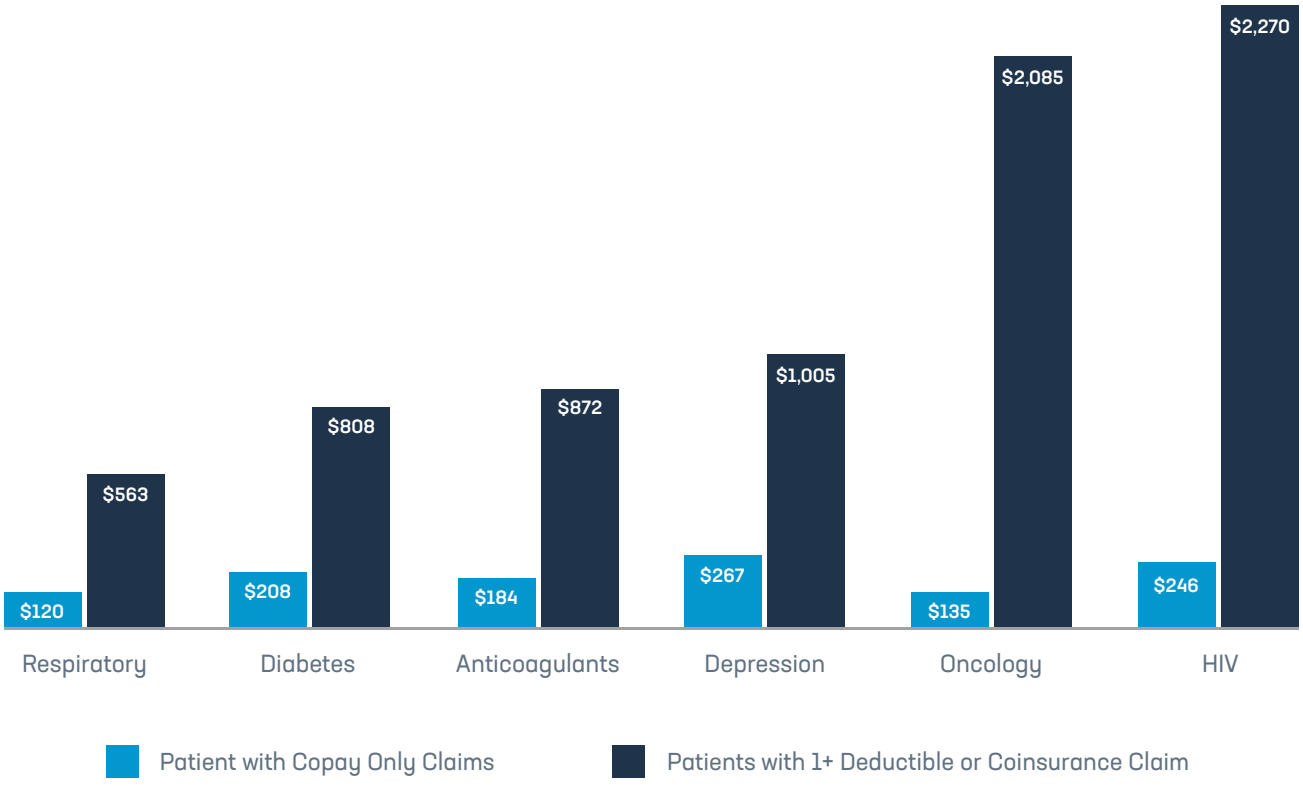
Figure 4: Share of Brand Condition-Specific Prescriptions with Out-of-Pocket Cost Exposure of $125 or More



Health plans and PBMs use of deductibles and coinsurance exposes patients to high out-of-pocket costs.

Patients whose out-of-pocket costs are based on the undiscounted list price of a medicine through the use of deductibles or coinsurance are exposed to significantly higher costs at the pharmacy counter each year compared to patients with only copays. Across the six therapy areas, annual out-of-pocket exposure for patients with deductibles and coinsurance ranged from nearly 4 times greater for patients taking brand depression medicines to more than 15 times greater for patients taking brand oncology medicines compared to patients with copay-only cost sharing.

Figure 5: Average Total Annual Out-of-Pocket Cost Exposure for Patients Taking Brand Medicines to Treat Chronic Conditions by Benefit Design, 2021



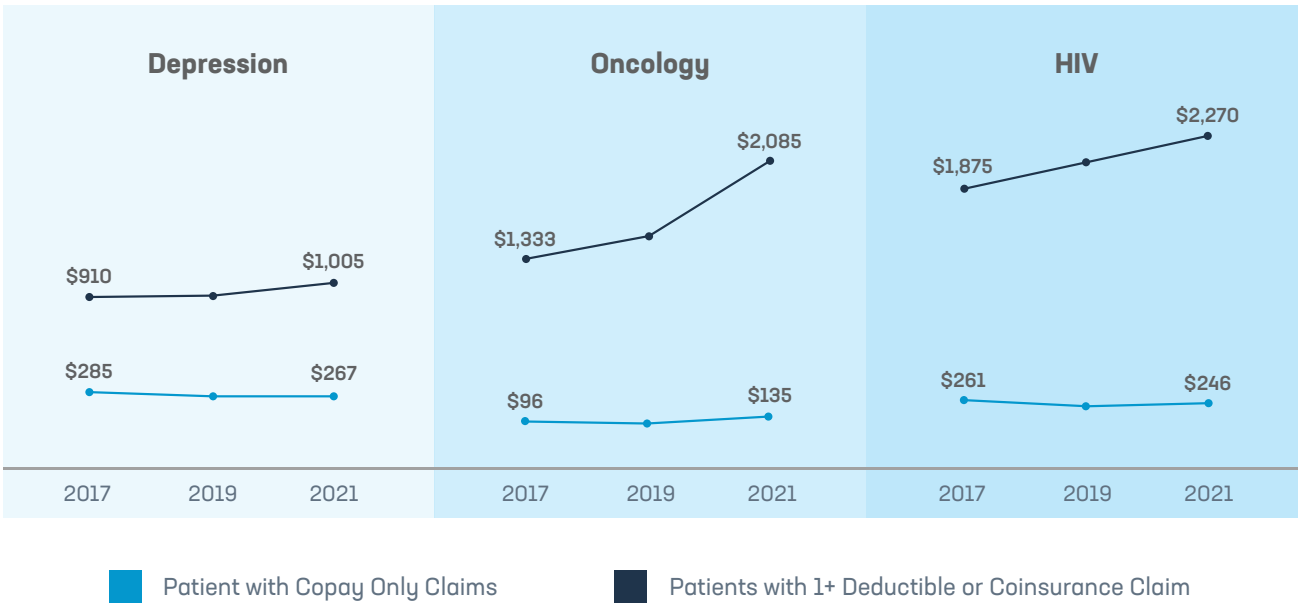
Note: Figures represent average annual out-of-pocket spending for commercially insured patients taking condition-specific brand medicine(s). Annual out-of-pocket spending includes both condition-specific and non-condition specific brand and generic medicines.

The difference between the amount health plans and PBMs require patients with deductibles and coinsurance to pay compared to the amount patients with copays are expected to pay is growing.

Health plans and PBMs did not substantially change annual out-of-pocket cost sharing requirements for patients taking brand medicines with copay-only cost sharing between 2017 and 2021. Meanwhile, patients who filled one or more claims in the deductible or with coinsurance were exposed to significant growth in cost sharing set by their health plans and PBMs. This resulted in a widening of the disparity in cost exposure between patients with cost sharing tied to undiscounted list prices and patients with copay-only cost sharing over the study period.

For example, in 2017, patients taking brand oncology medicines with deductibles or coinsurance were asked to pay $1,237 more than patients with copay-only cost sharing. In 2021, this difference increased to $1,950. Similarly, between 2017 and 2021, annual out-of-pocket exposure among patients taking brand HIV medicines with deductibles or coinsurance increased by 21%, while annual out-of-pocket exposure among patients with copay-only cost sharing declined by 6%.[6]

Figure 6: Average Total Annual Out-of-Pocket Cost Exposure for Patients Taking Brand Medicines to Treat Chronic Conditions by Benefit Design, 2021



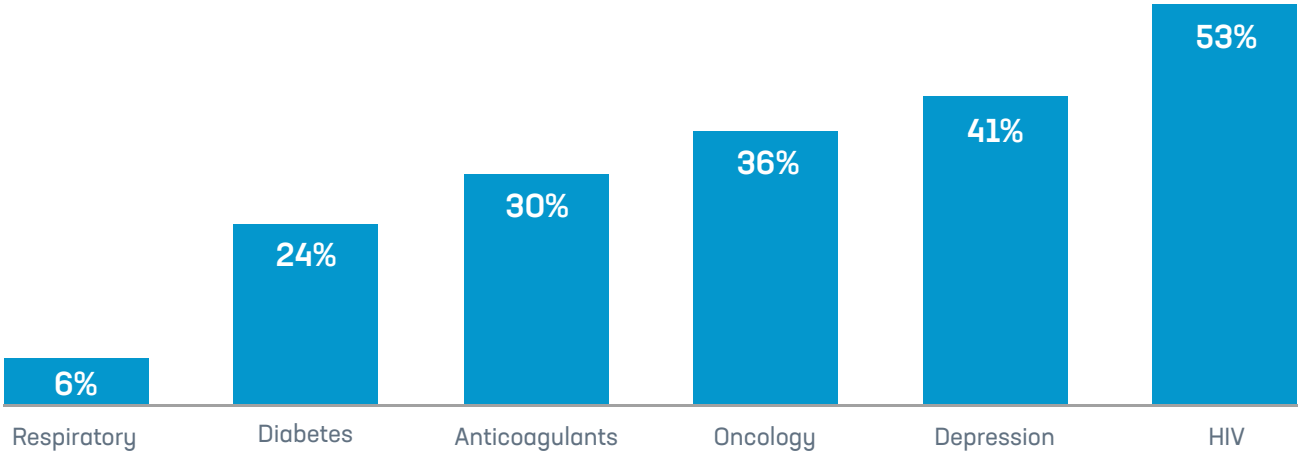
Note: Figures represent average annual out-of-pocket cost exposure for commercially insured patients taking condition-specific brand medicine(s). Cost exposure includes both condition-specific and non-condition specific brand and generic medicines. Copay assistance can lower the amount patients ultimately pay out-of-pocket for their medicines.

3. COPAY ASSISTANCE PROGRAMS CAN SIGNIFICANTLY IMPROVE AFFORDABILITY FOR PATIENTS.

Many patients with complex and chronic conditions use copay assistance programs offered by pharmaceutical manufacturers.

For many patients facing high out-of-pocket costs at the pharmacy, manufacturer copay assistance programs are an important source of financial support which can help to improve patient adherence and lead to improved patient outcomes.[7] Across the six therapy areas, the share of patients who used manufacturer copay assistance when filling a prescription for one or more brand medicines in 2021 ranged from 6% for those taking brand respiratory medicines to 53% for those taking brand HIV medicines.

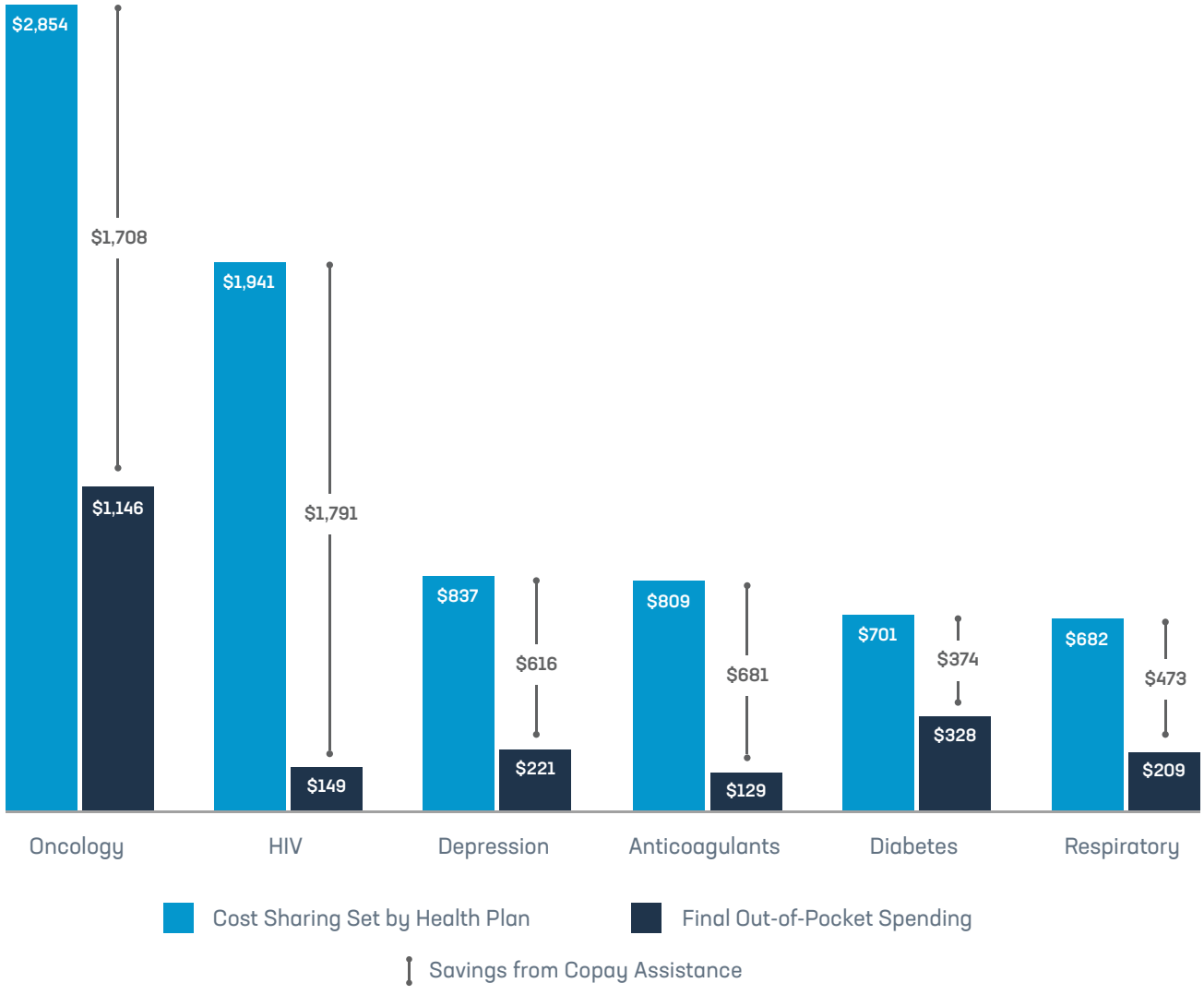
Figure 7: Share of Patients Using Manufacturer Copay Assistance to Fill One or More Prescriptions for Brand Medicines, 2021



Without manufacturer copay assistance programs, patients would likely pay significantly more out of pocket.

Had manufacturer assistance not been available, average patient out-of-pocket costs for brand medicines would have been 225% to 1,096% higher in 2019. Copay assistance, on average, helped patients taking brand HIV and oncology medicines with more than $1,700 and helped patients taking brand depression and anticoagulant medicines with more than $600 toward their out-of-pocket costs in 2021.

Figure 8: Average Cost Exposure and Final Out-of-Pocket Spending for Patients Using Manufacturer Copay Assistance to Fill One or More Brand Medicine Prescriptions, 2021

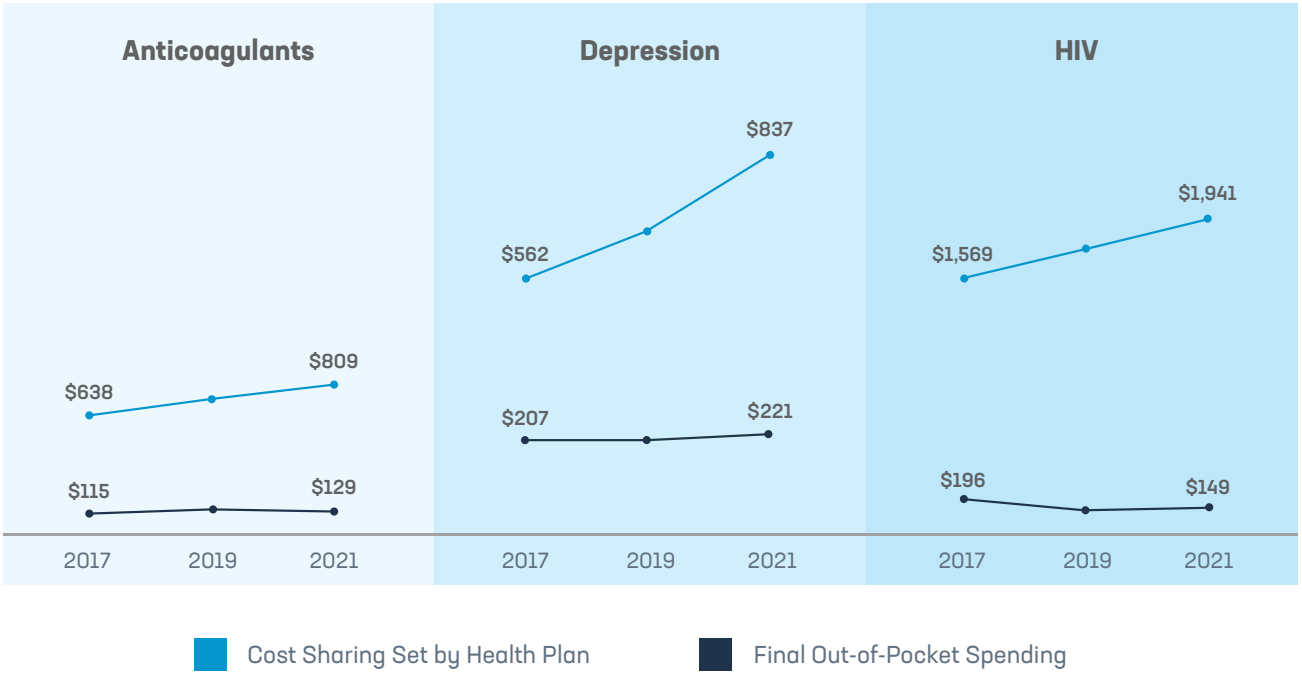


Note: Figures represent average annual out-of-pocket exposure and final spending for commercially insured patients taking condition-specific brand medicine(s) using copay assistance. Annual exposure and final spending out-of-pocket cost exposure and final out-of-pocket spending includes both condition-specific and non-condition specific brand and generic medicines.

Copay assistance has helped to mitigate the impact of increasing cost sharing set by health plans and PBMs.

As health plans and PBMs continue to shift more of the cost of care to patients, copay assistance helps to prevent patients with complex and chronic conditions from experiencing an erosion in the value of their insurance coverage. For example, among patients taking brand medicines for depression who used copay assistance, the annual cost sharing set by their health plans and PBMs increased by nearly 50% between 2017 and 2021. However, final annual out-of-pocket spending for these patients increased by just 7% over the four-year period, slower than the rate of inflation, due to the use of copay assistance.

Figure 9: Average Cost Exposure and Final Out-of-Pocket Spending for Patients Using Manufacturer Copay Assistance to Fill One or More Condition-Specific Brand Prescriptions



Discussion

The growing use of deductibles and coinsurance in the commercial market has substantially altered patient out-of-pocket costs sharing for brand medicines. For all six therapy classes, prescriptions filled in the deductible or with coinsurance represented a disproportionately large share of total patient out-of-pocket spending on brand medicines in 2021, in some instances upwards of 90%. Although health plans and PBMs often negotiate large rebates that significantly reduce the prices of brand medicines, patients with deductibles and coinsurance typically do not benefit from these savings and must pay cost sharing based on the full undiscounted prices.

> ***Not sharing rebate savings directly with patients effectively shifts more of the cost of care to patients, which disproportionately impacts individuals with complex and chronic conditions best managed with taking brand medicines.***

Over the 2017 to 2021 period, health plans and PBMs exposed many patients to increasingly high cost sharing for brand medicines. In contrast to the growth in patients' out-of-pocket cost exposure, average net prices for brand medicines grew by less than 3% annually, less than or in line with inflation, over this same period.[8] Today, health plans and PBMs require cost sharing of $125 or greater for one in every six brand depression and anticoagulant prescriptions, and nearly one in five brand HIV prescriptions. An extensive body of literature shows that patients facing high cost sharing are less likely to take medicines as prescribed and more likely to delay or forgo treatment, putting them at higher risk for expensive emergency room visits, avoidable hospitalizations and poorer health outcomes.[9]

Across all six therapy areas, manufacturer copay assistance helped patients pay their out-of-pocket costs for brand medicines at the pharmacy counter. In 2021, copay assistance helped patients taking brand HIV and oncology medicines with more than $1,700 and helped patients taking brand depression and anticoagulant medicines with more than $600 toward their out-of-pocket costs, on average.

> ***By helping patients pay their out-of-pocket costs, manufacturer copay assistance can help improve adherence to treatment and reduce the risk that patients will abandon their prescriptions at the pharmacy counter.[10]***

Policy Solutions

The findings of this analysis cast doubt on the wisdom and fairness of typical health plan and PBM practices and federal policies that could jeopardize commercially insured patients being able to afford their medicines. The following policy solutions can help ensure that patients have access to the medicines they need.

SHARE THE SAVINGS

Health insurance companies and PBMs should share at least part of their negotiated savings with patients at the pharmacy counter. Despite what health insurance companies claim, this will not drastically increase premiums. One study demonstrated that, even if health insurance companies were required to share all negotiated rebates with patients, premiums would increase at most 0.6%, while some patients could save nearly $1,000 each year on their medicine costs.[11] Fixing this broken part of the system and sharing these savings will give patients immediate relief and help them better afford the medicines they desperately need. Legislation can make sure rebates are shared directly with patients, thus lowering what they must pay at the pharmacy.

PROTECT PATIENT ASSISTANCE

Commercial health plans have increasingly adopted various programs that prevent manufacturer cost-sharing assistance from accumulating toward patient deductibles and annual out-of-pocket limits. These types of schemes run counter to the intent of reforms that aim to limit patient cost exposure when using health insurance coverage by requiring an annual limit on out-of-pocket costs. Ultimately these programs endanger the future of manufacturer cost-sharing assistance, leaving patients at risk of financial hardship due to the high and rising out-of-pocket costs health plans continue to demand. Moreover, since there is no explicit federal requirement that health plans notify patients when putting these programs in place, patients often do not know that their cost-sharing assistance is not being applied toward their deductible or annual out-of-pocket limit.

BAN ACCUMULATOR ADJUSTMENT PROGRAMS (AAPS)

Accumulator adjustment programs (AAPs) can substantially increase patients' out-of-pocket costs, increasing financial burden and the risk of prescription abandonment and non-adherence to treatment. Much like the surprise billings that distressed many insured patients in the medical setting, AAPs can surprise patients with thousands of dollars in unexpected and unaffordable costs at the pharmacy. In many cases, patients leave the pharmacy empty-handed as a result.[12]

Recognizing the clear risk to patient affordability and adherence, as of January 2023 sixteen states have already implemented bans on AAPs.[13] The federal government can build on these actions by passing similar legislation[14] or upholding the policy it finalized in the 2020 Notice of Benefits and Payment Parameters that health plans must count manufacturer cost-sharing assistance toward the annual limitation on cost sharing.

CLOSE THE ESSENTIAL HEALTH BENEFITS (EHB) LOOPHOLE

Health plans and PBMs also use copay maximizers to undermine the intended role of cost-sharing assistance. Copay maximizers impose higher cost sharing on certain medications by skirting the protection of the Affordable Care Act's (ACA) annual limit on cost sharing and designating them as non-Essential Health Benefits (EHB).[15] This can increase the out-of-pocket costs patients face for other needed drugs or health care services by slowing their progress through their health insurance benefit before they reach their annual cost-sharing limit. All covered drugs should be considered EHB so that the annual limitation on cost sharing applies. This policy, which would close the "EHB loophole," already exists in the individual and small-group markets and should be extended to all group health plans, whether insured or self-insured, and regardless of employer size.

PROHIBIT HEATH PLANS AND PBMS FROM DESIGNING BENEFITS BASED ON THE AVAILABILITY OF PATIENT ASSISTANCE

Benefit designs with copay maximizer programs create and apply separate prescription drug coverage requirements for patients who need certain medicines, including varying and higher cost-sharing obligations based on the availability of manufacturer cost-sharing assistance. Patients who need medicines targeted by these programs can be threatened with higher out-of-pocket costs unless they enroll in the copay maximizer program. These benefit designs shift costs of accessing medications onto patients who decide not to enroll in the copay maximizer program or onto cost-sharing assistance programs intended for patients. By focusing on medicines with available cost-sharing assistance programs, these copay maximizer programs affect certain patients based solely on their medical condition or need for a specific medicine. This targeting of certain medicines—and thus certain patients—is concerning and could run afoul of federal nondiscrimination requirements. Legislation should be implemented to prohibit payors from taking into account the availability of any patient assistance when designing, implementing, or administering benefits.

APPENDIX

Methodology

PhRMA engaged IQVIA's U.S. Market Access Strategy and Consulting team to analyze trends in out-of-pocket costs between 2017 and 2021 for commercially insured patients across multiple therapy areas, including anticoagulants, respiratory conditions, depression, diabetes, human immunodeficiency virus (HIV) and oncology. For each therapy area, patient inclusion criteria included a minimum of two medical claims with a diagnosis for the condition(s) of interest, as well as a subsequent prescription for at least one brand medicine to treat the condition(s) in the year of analysis. Patient cost exposure and final out-of-pocket spending for each therapy area included condition-specific and non-condition-specific brand and generic medicine spending among eligible patients. Analyses included paid prescription claims only; claims that were adjudicated and later reversed were included in the abandonment analysis only and were otherwise excluded. Patients were classified as being subject to deductibles or coinsurance if they filled one or more prescriptions with cost sharing equal to the total reimbursement amount, or a percentage thereof, regardless of therapy area. Differences between cost exposure and final patient out-of-pocket spending reflect reimbursement amounts from secondary payers, which are most commonly manufacturer copay assistance programs but can include any additional support outside of traditional commercial insurance, including the AIDS Drug Assistance Program, charitable foundation support and supplemental commercial coverage. Manufacturer copay assistance programs that are administered via debit cards are not captured in IQVIA's data and therefore are not reflected in patients' final out-of-pocket spending.

Sources

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2 PhRMA. Deductibles and Coinsurance Drive High Out-Of-Pocket Costs for Commercially Insured Patients Taking Brand Medicines. November 2022.

3 Fein A. The 2022 Economic Report on U.S. Pharmacies and Pharmacy Benefit Managers. Drug Channels Institute, March 2022.

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9 *See, for example:* Ta J, et al. Health care resource utilization and costs associated with non-adherence and non-persistence to antidepressants in major depressive disorder. *Journal of Managed Care & Specialty Pharmacy*, 2021;(27): 223-239.

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15 *See* David Cook, IPBC and SaveOnSP Training-20210216 1901-1, VIMEO (Feb 17, 2021), https://vimeo.com/513414094 (describing SaveOnSP's program to get the "most lucrative savings" by reclassifying specialty drugs as "non-essential," allowing SaveonSP to "operate outside of those [Affordable Care Act] rules"); PrudentRx Copay Program for Specialty Medications, https://personnel.ky.gov/KEHP/PrudentRx%20Overview.pdf (indicating that "certain specialty drugs do not qualify as 'essential health benefits'").

Data Tables

Table 1: Share of Final Patient Out-of-Pocket Spending for Brand Medicines by Type of Cost Sharing, 2021

	Copay	Coinsurance	Deductible
Anticoagulants	43.5%	27.6%	28.9%
Depression	37.6%	17.5%	45.0%
Diabetes	57.9%	18.2%	23.9%
HIV	18.9%	18.1%	63.1%
Oncology	6.9%	18.3%	74.8%
Respiratory	55.1%	20.1%	24.9%

Table 2: Share of Brand Prescriptions by Type of Cost Sharing, 2021

	Copay	Coinsurance	Deductible
Anticoagulants	78.0%	13.2%	8.8%
Depression	81.8%	10.2%	8.0%
Diabetes	90.8%	6.3%	2.9%
HIV	83.7%	9.4%	6.9%
Oncology	86.8%	6.8%	6.4%
Respiratory	87.3%	7.3%	5.4%

Table 3: Average Annual Patient Initial Cost Exposure, 2017 to 2021

	2017	2018	2019	2020	2021
Anticoagulants	$704.44	$754.44	$729.38	$775.35	$759.42
Depression	$819.71	$872.49	$840.58	$900.13	$906.28
Diabetes	$743.36	$775.13	$698.18	$733.33	$712.38
HIV	$1,327.50	$1,432.06	$1,468.24	$1,578.96	$1,688.57
Oncology	$954.58	$1,004.60	$1,040.03	$1,071.79	$1,369.58
Respiratory	$404.79	$420.60	$406.76	$451.09	$464.29

Among patients taking brand medicines to treat condition, includes all patient spending on medicines (brand and generic, condition-specific and comorbid medicine spending).

Table 4: Average Annual Patient Final Out-of-Pocket Costs, 2017 to 2021

	2017	2018	2019	2020	2021
Anticoagulants	$516.97	$546.23	$494.75	$505.08	$494.34
Depression	$605.72	$605.13	$541.16	$558.03	$559.07
Diabetes	$593.23	$608.66	$535.99	$564.96	$565.71
HIV	$422.10	$433.11	$388.68	$415.17	$422.47
Oncology	$513.17	$526.47	$564.92	$591.83	$763.17
Respiratory	$339.80	$348.51	$324.85	$361.29	$380.65

Among patients taking brand medicines to treat condition, includes all patient spending on medicines (brand and generic, condition-specific and comorbid medicine spending).

Table 5: Average Patient Out-of-Pocket Spending by Benefit Design, 2021

	Patients with copay-only claims	Patients with 1+ deductible OR coinsurance claim	Patients with 1+ coinsurance claim	Patients with 1+ deductible claim
Anticoagulants	$146.42	$562.26	$650.73	$570.75
Depression	$200.08	$614.63	$705.49	$630.52
Diabetes	$182.77	$637.93	$755.61	$650.26
HIV	$82.51	$559.53	$605.98	$596.41
Oncology	$115.55	$1,138.73	$1,242.42	$1,178.23
Respiratory	$110.69	$457.98	$560.96	$466.11

Total out-of-pocket cost exposure for patients taking brand medicines to treat condition, includes all patient spending on medicines (brand and generic, condition-specific and comorbid medicine spending).

Table 6: Share of Brand Prescriptions with Cost Exposure Greater than $125, 2017 to 2021

	2017	2018	2019	2020	2021
Anticoagulants	11.1%	13.4%	14.4%	15.8%	17.2%
Depression	13.3%	13.6%	13.9%	14.8%	15.6%
Diabetes	8.1%	8.6%	7.4%	7.6%	7.1%
HIV	12.3%	14.7%	17.0%	18.6%	19.5%
Oncology	13.5%	13.2%	13.1%	12.9%	15.1%
Respiratory	4.8%	5.3%	5.6%	6.9%	7.4%

Table 7: Copay Assistance Utilization and Initial Cost Exposure and Final Out-of-Pocket Spending Among Copay Assistance Utilizers, 2021

	Share of Patients Using Manufacturer Copay Assistance	Initial Cost Exposure Among Patients Using Copay Assistance	Final Out-of-Pocket Spending Among Patients Using Copay Assistance
Anticoagulants	29.9%	$809.43	$128.90
Depression	40.5%	$837.22	$220.89
Diabetes	24.0%	$701.15	$327.54
HIV	52.7%	$1,940.69	$149.22
Oncology	35.9%	$2,854.11	$1,146.27
Respiratory	6.3%	$682.31	$209.41

Among patients taking brand medicines to treat condition, includes patients who use copay assistance for one or more prescriptions filled in 2021.

Table 8: Rate of Abandonment of Condition-Specific Brand Medicine by Type of Cost Sharing, 2021

	$0/Zero Cost	Copay	Coinsurance	Deductible
Anticoagulants	0%	10%	24%	37%
Depression	8%	14%	41%	60%
Diabetes	9%	14%	42%	61%
HIV	12%	13%	17%	24%
Oncology	15%	22%	28%	51%
Respiratory	9%	17%	43%	58%