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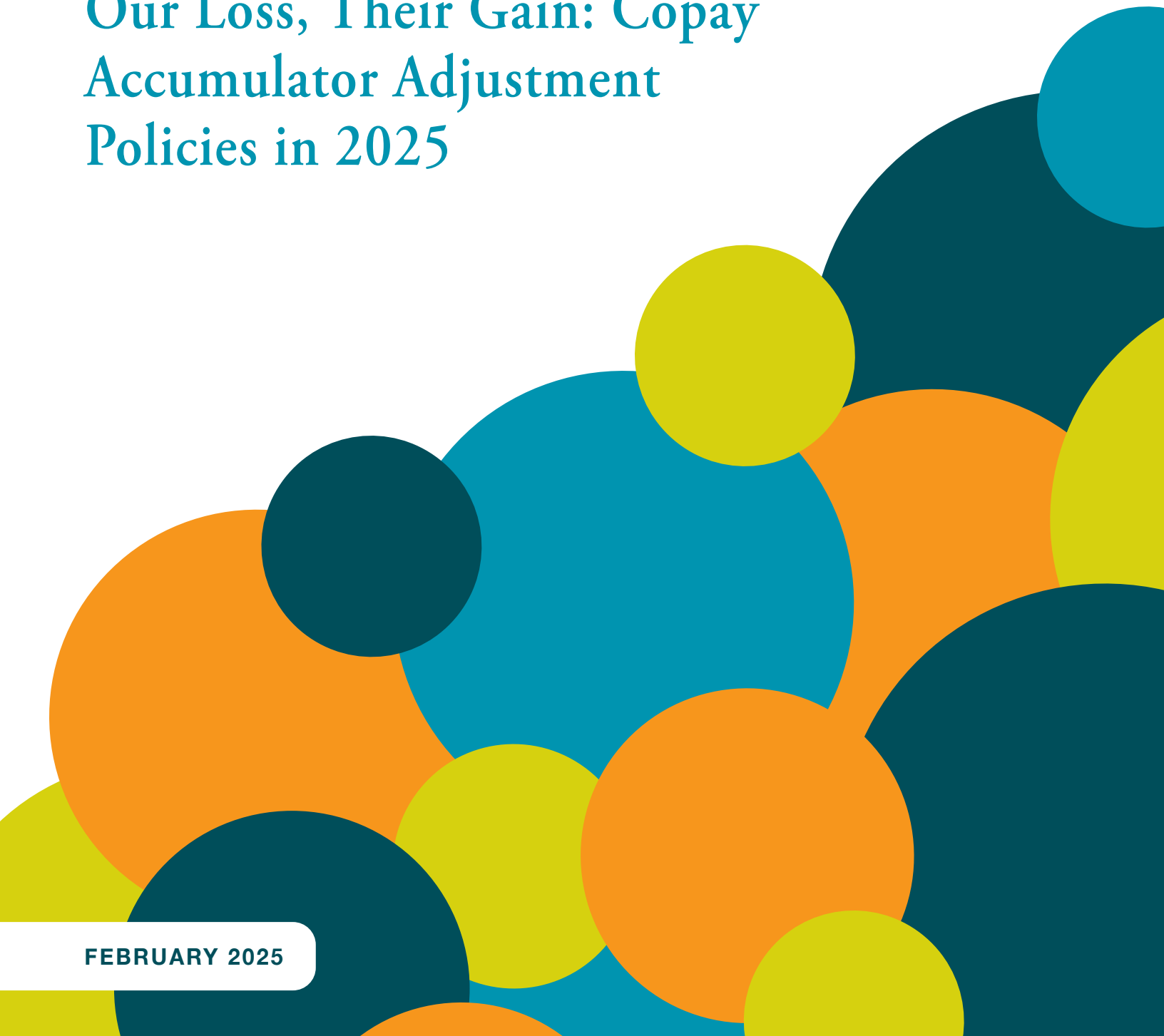
Our Loss, Their Gain: Copay Accumulator Adjustment Policies in 2025



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Introduction

People living with serious, complex chronic illness such as HIV and viral hepatitis often rely on high-cost medications to manage their conditions and maintain their health. For many of these medications, there is no generic or less expensive alternative. But affording these medications has become increasingly difficult, *even for people who have health insurance*. As a result, many people living with serious chronic conditions have turned to patient copay assistance programs run by charitable organizations or pharmaceutical manufacturers for help paying copayments and coinsurance for specialty drugs.

Since 2017, The AIDS Institute has monitored the rise of "copay accumulator adjustment policies" (CAAPs), used by health insurance companies and the pharmacy benefit managers (PBMs) they employ to administer their prescription drug benefits. Health insurance plans that include a CAAP pocket copayments made by enrollees using third-party copay assistance without crediting the payments to the enrollee's annual deductible or out-of-pocket limit. These policies undermine important patient protections enacted in the Affordable Care Act (ACA) and make it more difficult for people trying to manage a chronic illness to afford medicine they need.

The federal government has struggled to decide how and whether to address this practice. In 2019 and 2020, the Department of Health and Human Services (HHS), issued contradictory regulations that first generally prohibited CAAPs, and then allowed insurers to adopt them.[1] But in late 2023, a U.S. District Court for the District of Columbia ruled that health insurers and their PBMs must count all copayments made by or on behalf of an insurance enrollee for prescription drugs toward that enrollee's annual deductible and out-of-pocket, unless that drug has an available generic equivalent, for all non-grandfathered health insurance plans in all 50 states.[2]

State governments have been more clear: since 2020, 21 states, the District of Columbia, and Puerto Rico have enacted laws restricting the use of CAAPs. These state laws apply to health insurance plans subject to state regulation (generally individual and small group plans, but not large employer plans), protecting an estimated 26 million people – 19% of all people enrolled in commercial health insurance plans in the U.S.[3] Despite these laws and the federal rule limiting use of CAAPs in all non-grandfathered health insurance plans, too many people living with chronic illness will continue to face CAAPs in their health insurance plans in 2025.

The AIDS Institute reviewed individual health insurance plans available for 2025 on the health insurance marketplaces in all 50 states and D.C. Our analysis shows that nationwide, more than 4 in 10 plans include a CAAP, and that in

39 states, at least one plan includes a CAAP. A list of the plans in each state that include a CAAP can be found in Appendix 1, at the end of this report. Although the data in this report are limited to individual health insurance plans, other research has shown that these policies are also widespread in employer health insurance plans.[4]

Federal legislation that would restrict the use of CAAPs in all health insurance plans in the U.S., including employer-sponsored plans, was introduced in Congress in 2023. The "Help Ensure Lower Patient (HELP) Copays Act," garnered significant bipartisan support in both the Senate and the House. It did not come to a vote and is expected to be reintroduced in 2025.

We urge Members of Congress, officials at HHS, and state insurance regulators to use the tools at their disposal to protect patients and ensure that copayments paid to insurers and PBMs on behalf of their enrollees are counted toward the enrollee's annual out-of-pocket expenses.

Methodology

Copay accumulator adjustment policies (also called copay diversion 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 policies are and how they affect patients' insurance, The AIDS Institute conducted original research, reviewing individual market health plans in all 50 states and D.C.[5] We examined all available policy documents from all insurance carriers that offered plans, looking for specific language regarding enrollee cost-sharing and copay accumulator policies. When those documents were ambiguous or unavailable, we called customer service lines to speak with insurance plan representatives.

Some plans do not make policy documents available online, making it difficult for people to determine its policy on copay assistance. Calling customer service representatives to ask about the plan's application of copay diversion programs is time-consuming and arduous, with many transfers and long wait times before speaking with someone who may (or may not) know the plan's policies.

Across all states, 18 plans failed to provide plan documents online during the open enrollment shopping process; of the 18 plans that required phone calls, 13 have copay accumulator policies. In one case, during a phone inquiry, we were told that plan information about copay assistance policies would only be made available after purchasing a plan. Health insurance is one of the only products that a person must buy without knowing exactly what they are purchasing.

Findings

Our analysis of individual health insurance plans offered to individuals and

families through the Affordable Care Act marketplaces for 2024 found that:

Use of CAAPs is Widespread

- Nationwide, **more than 40%** of all individual marketplace plans we reviewed have copay accumulator adjustment policies, but there is wide variation state to state.[6]
- In 11 states, Washington DC, and Puerto Rico, **zero** plans include CAAPs, ensuring that patients receive the full benefit of patient copay assistance. These states scored a **Grade A** for 2025.[7]
    - In **10** states plus **D.C.** and **Puerto Rico**, state laws restrict CAAPs in 2025 (AR, AZ, CT, DC, KY, ME, NM, NY, PR, VA, VT, WV)[8]
    - Only **1** state (HI), had all plans voluntarily opt not to include CAAPs when not obligated by law or regulation.[9]
- In **39** states, there is **at least 1** plan with a copay accumulator adjustment policy.
    - In **9** states, up to **25%** of available plans have a copay accumulator adjustment policy. These states earned a **Grade B** for 2025: DE, GA, IL, LA, NJ, NC, OR, WA, TX. All of these states, except NJ, has a law restricting use of CAAPs.
    - In **13** states, between **25% and 50%** of plans include a CAAP. These states earned a **Grade C** for 2025: AK, CA, CO, MA, MD, MN, MS, NV, NH, ND, OK, RI, TN.
    - In **7** states, **50% - 75%** of available plans include a CAAP. These states earned a **Grade D** for 2025: AL, IN, KS, MI, NE, OH, SD.
    - In **10** states, **75% - 100%** of available plans included a CAAP. These states earned a **Grade F** for 2025: FL, IA, ID, MO, MT, PA, SC, UT, WI, WY.
- **30 plans**, located in **13 states**, only allow CAAPs when the copay assistance is for a brand medication *with no available generic equivalent*. These policies align with the current federal regulation restricting use of CAAPs and with some state laws that restrict use of CAAPs. (We did not categorize these plans as having a CAAP for the purposes of this report.)

CAAP Information is Hard to Find

Information about CAAPs is confusing and difficult for enrollees to find. This information is difficult to locate and is often written in confusing language. People shopping for coverage may need to call insurers to learn about any copay accumulator adjustment policies if the information is not available in plan materials. However, customer service representatives are not always knowledgeable about their company's policy and cannot answer accurately. In some cases, we were unable to reach a representative at all, suggesting that people shopping for coverage may have the same problem.

- **18** plans in **11** states did not make plan and policy documents available online during the open enrollment period: CA, FL, ID, KS, MD, MI, MO, NJ, NY, PA, SD.
    - **13** of those plans have a CAAP, according to customer service representatives.
    - Insurers and PBMs are not required to make information about CAAPs clear for patients shopping for coverage.

State Laws and Federal Rules Must be Enforced

Plans are not always in compliance with state laws and regulatory requirements that restrict the use of CAAPs. More enforcement by state Departments of Insurance and the U.S. Department of Health and Human Services (HHS) is needed. Our research found:

- In **13** of the **21** states, DC, and Puerto Rico that have enacted laws restricting the use of CAAPs, **at least 1** plan continues to include CAAP language.
- In both of the states that required insurers to follow the 2020 federal rule restricting CAAPs in the qualified health plan certification and rate filing process for 2025, there was **at least 1 plan** with CAAP language.[10] (MN and NV)

In the 2025 Notice of Benefit & Payment Parameters (NBPP), CMS clarified that all covered drugs are considered essential health benefits (EHB) and are subject to the ACA's cost-sharing protections. This prohibits plans requiring enrollment in a third-party program before it will cover "certain" specialty drugs.

- These third-party programs attempt to find alternative sources of payment for these drugs outside of the plan's regular coverage. This may include international purchasing, grants, or other means, in addition to manufacturer copay assistance.
    - Plans in **2** states have changed their policies for 2025 as a result of this clarification (ID, MT).
    - Plans in **2** states continue to only cover the drugs if the third-party program cannot secure the prescription from an alternative source (UT, WY).
- In **12** states, at least one plan includes a "variable copay program" that enables the plan to take advantage of the maximum amount of copay assistance available for specialty drugs without counting those amounts toward the enrollee's cost-sharing requirements (IN, MD, MO, MS, NE, NH, OH, PA, RI, UT, WI, WY).
    - Copay amounts are not available in plan materials. They may be set at an amount that divides the copay assistance into 12 equal payments, or they may seek to maximize the amount of copay assistance they receive early in the year.
    - Copay assistance is not counted toward the enrollee's annual cost-sharing requirement.

2025 State Grades

State	CAAPs	Grade	Year State Law Restricting CAAPs in Effect
Arizona	0.0%	A	2020
Arkansas	0.0%	A	2022
Connecticut	0.0%	A	2022
DC	0.0%	A	2025
Hawaii	0.0%	A	
Kentucky	0.0%	A	2022
Maine	0.0%	A	2023
New Mexico	0.0%	A	2024
New York	0.0%	A	2023
Vermont	0.0%	A	2025
West Virginia	0.0%	A	2020
Virginia	0.0%	A	2020
Delaware	25.0%	B	2023
Georgia	22.2%	B	2021
Illinois	10.0%	B	2020
Louisiana	25.0%	B	2022
New Jersey	16.7%	B	
North Carolina	11.1%	B	2022
Oregon	16.7%	B	2025
Washington	8.3%	B	2023
Texas	13.3%	B	2024
Alaska	50.0%	C	
California	50.0%	C	
Colorado	33.3%	C	2025
Maryland	50.0%	C	

Note: States listed in italics have a state law or rule restricting use of CAAPs in effect in 2025.

State	CAAPs	Grade	Year State Law Restricting CAAPs in Effect
Massachusetts	28.6%	C	
Minnesota	40.0%	C	2025 Rate Filing Requirement
Mississippi	40.0%	C	
Nevada	50.0%	C	2025 Rate Filing Requirement
New Hampshire	50.0%	C	
North Dakota	33.3%	C	
Oklahoma	28.6%	C	2022
Rhode Island	50.0%	C	
Tennessee	33.3%	C	2022
Alabama	66.7%	D	
Indiana	66.7%	D	
Kansas	71.4%	D	
Michigan	70.0%	D	
Nebraska	60.0%	D	
Ohio	69.2%	D	
South Dakota	66.7%	D	
Florida	78.6%	F	
Idaho	87.5%	F	
Iowa	80.0%	F	
Missouri	77.8%	F	
Montana	100.0%	F	
Pennsylvania	90.9%	F	
South Carolina	85.7%	F	
Utah	85.7%	F	
Wisconsin	85.7%	F	
Wyoming	100.0%	F	

Note: States listed in italics have a state law or rule restricting use of CAAPs in effect in 2025.

Discussion

Health care is expensive. That's why people buy health insurance – so when they need health care, they will be able to afford that care. But over the past decade, out of pocket costs for health care have been going up as insurance plans include higher deductibles (the amount you pay before your insurance "kicks in") and higher cost-sharing (the amount you pay out-of-pocket when you get health care after your insurance "kicks in").

For example, since 2014, the annual deductible for a silver-level health insurance plan has doubled (from $2,425 to $4,928).[11] The Affordable Care Act included an important protection for people with high health care needs, capping total annual out-of-pocket expenses (including deductibles and cost-sharing). But the annual out-of-pocket limit increases every year, and according to a recent analysis, it is increasing faster than wages.[12] In 2025, the individual out-of-pocket limit on health care expenses is $9,200, and it is twice that amount for a family ($18,400). The maximum out-of-pocket limit in 2026 is projected to be over $10,000. The average out-of-pocket limit in 2025 is $8,277 – more than most people have in the bank.[13]

Most people will never spend as much as their annual deductible – one analysis found that in 2019, 68% of the U.S. population spent less than $500 out-of-pocket on health care expenses. But 8% of the U.S. population spent more than $2,500 out-of-pocket on health care.[14] And many people with serious, chronic illnesses, for whom the annual cost of care can be tens- or hundreds- of thousands of dollars, will reach the maximum out-of-pocket limit every year.

Financial hardship is a real threat for many people with chronic conditions; 33% of people with marketplace plans reported medical debt, and people with chronic illness are more likely to have medical debt. The high cost of healthcare can drive patients to take risky actions such as skipping doses, failing to fill a prescription, or foregoing necessary care, jeopardizing their health to avoid another medical bill.

How Copay Assistance Works

People who rely on high-cost specialty medications to treat a chronic illness often use copay assistance to help meet their annual deductible and cost-sharing. Copay assistance is available from pharmaceutical manufacturers and also some charitable foundations.

Specialty drugs are expensive, so insurance plans employ a host of tools to ensure that only people who need them are able to get coverage for them. Insurers and PBMs set the plan's drug

formulary (the drugs that the plan will cover), and the coverage requirements, which can include prior authorization (to ensure that a particular drug is medically necessary for a given patient), step therapy (to ensure that the patient tries less expensive options before more expensive options), and specifying which pharmacy must be used to dispense the drug. Copay assistance helps people afford the medication after their doctor has prescribed it, and after their health insurer/PBM has utilized these tools to ensure that the prescription is medically necessary for them.

Copay assistance is paid on behalf of a patient to meet their share of the cost of a drug. In plans that have a CAAP, the insurer/PBM accepts payment of that assistance on an enrollee's behalf, and the enrollee's cost-sharing is considered paid so that the pharmacy can dispense the drug. However, that payment is not counted toward the enrollee's annual deductible and out-of-pocket limit; instead, the plan continues to charge the patient for health care services as if that payment had never been made. As a result, people living with chronic illness may be unable to gain the full protection of having health insurance.

It should be noted that, despite concerns that manufacturer copay assistance may affect provider and patient choice of drug, insurers and PBMs do not rely on high cost alone to deter patients from using expensive medications. They also employ strict measures to limit coverage of high-cost prescription drugs, such as limiting which drugs are covered by the plan, step therapy, generic substitution, prior authorization, and pill quantity limits. It is only once the insurer and/or PBM has approved use of a specialty or high-cost brand medication that patients turn to copay assistance to help cover their share of the cost for the treatment.[15]

Federal Regulation

The current federal rule about copay accumulator adjustment policies was finalized in the 2020 NBPP on April 25, 2019. The 2020 rule significantly restricts the use of CAAPs, only allowing them for brand drugs that have an available and medically appropriate generic equivalent.[16] The rule further clarifies that copay assistance amounts must be counted toward the enrollee's annual limit on cost-sharing if the insurer or PBM have approved use of the brand drug because the generic is not available or medically appropriate.

HHS crafted the 2020 rule specifically to address a key concern raised by health economists, that the availability of copay assistance for high-cost brand drugs that have a generic alternative may lead providers and patients to choose those higher cost drugs instead of a less expensive

generic alternative, which could have long-term implications on overall health care spending.[17] The 2020 rule addresses this concern by allowing CAAPs only where there is a choice between a brand drug and a generic alternative.

Before the 2020 rule went into effect, HHS announced that it would not implement this provision, and that it would revisit the issue in the 2021 NBPP. The 2021 NBPP reversed the 2020 rule by allowing insurers and PBMs to adopt CAAPs for all prescription drugs regardless of whether there is an available, medically appropriate generic alternative, to the extent allowable by state law.

In response to a suit filed against the HHS on behalf of patients, the U.S. District Court for the District of Columbia ruled in late 2023 that HHS cannot allow health insurers and their PBMs to decide whether manufacturer copay assistance must be counted toward an enrollee's cost-sharing limit. The court declared that, unless or until HHS issues a new rule on the matter, insurers and PBMs must follow the 2020 rule. However, HHS has so far declined to enforce that rule. Instead, the agency has announced plans to update the cost-sharing rule with new language. That means that many insurance plans continue to include CAAPs in 2025.

Additionally, in the final NBPP, HHS reiterated that all prescription drugs covered by individual and small group health plans are considered to be part of the Essential Health Benefits (EHB) package, and therefore subject to the AHA's cost-sharing protections. This rule is important because it prevents insurers and PBMs from treating specialty drugs differently than other covered prescription drugs with response to cost-sharing. While this clarification only applies to the state-regulated marketplace plans, the Department of Labor, Treasury, and HHS announced their intention to issue a complimentary rule that would apply to employer-sponsored plans.

State Laws Restricting Copay Diversion Policies

While the federal government has not prohibited CAAPs, HHS' 2021 NBPP allowed states to do so. To date, 21 states, the District of Columbia, and Puerto Rico have adopted laws requiring insurance plans and PBMs to count the value of copay assistance toward an enrollee's annual deductible and out-of-pocket limit in all or most circumstances:

- To date, 9 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: CT, DE, IL, LA, NM, NY, OK, VA, WV, and PR.

- 12 more states and the District of Columbia enacted laws 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 is available: AZ, AR, CO, DC, GA, KY, ME, NC, OR, TN, TX, WA, and VT.

These state laws help protect people with individual and small group coverage from copay accumulator adjustment policies, because state Departments of Insurance have the responsibility to regulate those plans. Yet, these laws are ineffective if state regulators fail to enforce the laws. In 2025, we reviewed plan policy documents for individual plans in the 21 states and DC to see how insurers are implementing their state's laws. Our analysis revealed that in 11 states, at least 1 insurer continues to include CAAPs, in apparent violation of state law. CO, DE, GA, IL, LA, NC, OK, OR, TN, TX, and WA. Many of these states have had laws in place for several years.[18]

Additionally, insurance regulators in MN and NV issued notice as part of the qualified health plan certification and rate review process for 2025 that insurers must abide by the federal requirements regarding copay assistance in the 2020 NBPP, meaning CAAPs may only be applied under certain circumstances; however, both states had insurers that continue to include CAAPs in their policies. Laws and regulations are meaningless unless properly enforced. It is up to state regulators and policy makers to ensure that patients are protected and upheld as guaranteed by laws and regulations. In total, the 23 states (including MN and NV), DC, and Puerto Rico that have enacted protections for patients who rely on copay assistance have created momentum and paved the way for additional states to follow suit. Similar bills have been introduced in a number of state legislatures for the 2025 legislative sessions.

These proactive actions by states are a step forward for patient protections; however state laws do not solve the problem entirely because most large employer-sponsored insurance plans are regulated by the federal government rather than state governments, leaving many insured individuals vulnerable to the harms of CAAPs. This means that while these state laws help many people living with chronic illness, the full scope of the problem cannot be resolved without federal regulations or legislation. Advocates continue to pursue multiple avenues of policy change, including state and federal laws and regulatory action.

HELP Copays Act

The Help Ensure Lower Patient (HELP) Copays Act was introduced in both the Senate and the

House in 2023 with significant bipartisan support.[19] The bill has two parts: the first would require insurers and PBMs to count copay assistance payments that insurers and PBMs receive on an enrollee's behalf toward that enrollee's annual cost-sharing requirement. The second part would ensure that when a health plan covers prescription drugs, all of the covered drugs are considered part of the "essential health benefits" (EHB) package. That designation is important because the Affordable Care Act's limits on out-of-pocket costs only apply to services that are part of the essential health benefits package.

If enacted into law, the HELP Copays Act would require that all insurance plan subject to the requirements of the Affordable Care Act, whether they are purchased by an individual or family or provided by an employer to apply copay assistance payments toward their enrollees' annual cost-sharing limits.

Conclusion

At the most basic level, copay accumulator adjustment policies discriminate against people living with chronic illness, interrupting their access to needed treatment and threatening their health. Moreover, they enable insurers and PBMs to profit by accepting copay assistance payments intended to help enrollees meet their annual cost-sharing obligations. Federal and state policymakers can address this issue by enforcing the current regulation prohibiting this practice, or by enacting legislation to protect access to care for people living with chronic illness who have health insurance.

Endnotes

1 See Notice of Benefit and Payment Parameters, 2020 and 2021 (finalized in 2019 and 2020, respectively). US Department of Health and Human Services, *Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2020*, (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 ; US Department of Health and Human Services, *Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2021*, (May 15, 2020), https://www.federalregister.gov/documents/2020/05/14/2020-10045/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2021

2 HHS, *Notice of Benefit and Payment Parameters for 2020*, ii. Cost-Sharing Requirements and Drug Manufacturers' Coupons, 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, "Copay assistance for brand drugs that have a generic equivalent must also be counted when an enrollee has gotten approval from their insurer to take the brand drug instead of the generic through an appeals or exceptions process. Most of the prescription drugs for which copay assistance is available do not have an available generic equivalent."

3 Avalere, "State Copay Accumulator Bans Will Affect 19% of US Commercial Lives," June 22, 2023, https://avalere.com/insights/state-copay-accumulator-bans-impact-11-of-us-commercial-lives.

4 Adam Fein, "Copay Accumulator and Maximizer Update: Adoption Expands as Legal Barriers Grow," Drug Channels, February 14, 2024, https://www.drugchannels.net/2024/02/copay-accumulator-and-maximizer-update.html.

5 The individual market is the health insurance market for coverage that is available to people who do not get health coverage through their employer or a government program. It is bought directly from an insurer.

6 This figure does not include the 16 plans that have a copay accumulator adjustment policy that only applies to brand drugs for which there is an available generic alternative.

7 Grades were assigned based on percentage of plans in a state that included a copay accumulator adjustment policy. States assigned a Grade A have 0% copay accumulators; Grade B have 1%-25% of plans with copay accumulators; Grade C have 25%-50% of plans with copay accumulators; Grade D have 50%-75% of plans with copay accumulators; Grade F have 75%-100% of plans with copay accumulators.

8 CO and DC enacted state laws banning CAAPs in 2023 that will go into effect in 2025. We did not review plans in states that had enacted laws prohibiting CAAPs, except CO and DC.

9 One plan in HI and two plans in DC include a copay accumulator adjustment policy that only applies to brand drugs for which there is an available generic alternative.

10 MN and NV state departments of insurance will enforce the 2020 Notice of Benefit & Payment Parameters rule as part of the qualified health plan certification and rate review process; in alignment with the 2020 NBPP, issuers may only apply CAAPs in limited circumstances.

11 CMS, Plan Year 2025 Qualified Health Plan Choice and Premiums in HealthCare.gov Marketplaces, (Oct 25, 2024), https://www.cms.gov/files/document/2025-qhp-premiums-choice-report.pdf.

12 Matthew Rae, Krutika Amin, and Cynthia Cox, "ACA's maximum out-of-pocket limit is growing faster than wages," Peterson-KFF Health System Tracker, July 20, 2022, https://www.healthsystemtracker.org/brief/aca-maximum-out-of-pocket-limit-is-growing-faster-than-wages/.

13 Lora Shinn, "Open Enrollment is Underway, and Premiums are Up 4%. You can pay much less." Investopedia, November 4, 2024, https://www.investopedia.com/obamacare-premiums-are-up-4-percent-heres-how-you-can-pay-much-less-8737935#:~:text=In%202025%2C%20the%20maximum%20MOOP,lead%20to%20serious%20financial%20issues. Data are from Healthcare.gov, health plan data sets 2025.

14 Peterson-KFF, Health System Tracker, Out-of-Pocket Spending: Higher out-of-pocket health spending per person can lead to more difficulty accessing care, (Accessed February 2024), https://www.healthsystemtracker.org/indicator/access-affordability/out-of-pocket-spending/#Household%20out-of-pocket%20spending%20as%20a%20share%20of%20current%20health%20expenditures,%202021.

15 Angela Maas, Report Shows Evolution in Utilization Management for Specialty Drugs, Pharmaceutical Strategies Group, (July 21, 2022), https://www.psgconsults.com/blog/report-shows-evolution-in-utilization-management-for-specialty-drugs.

16 Specifically, the 2020 NBPP creates §156.130 (h) Use of drug manufacturer coupons. For plan years beginning on or after January 1, 2020: (1) Notwithstanding any other provision of this section, and to the extent consistent with state law, amounts paid toward cost sharing using any form of direct support offered by drug manufacturers to enrolles to reduce or eliminate immediate out-of-pocket costs for specific prescription brand drugs that have an available and medically appropriate generic equivalent are not required to be counted toward the annual limitation on cost sharing (as defined in paragraph (a) of this section).

17 HHS. 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#p-895.

18 The effective date of state laws can be found in the state grade table.

19 S.1375/HR 830 Help Ensure Lower Copays Act, https://www.congress.gov/bill/118th-congress/senate-bill/1375/text.

Appendix 1: Copay Assistance Diversion Policies in 2024 Marketplace Health Plans

State	Issuer	CAAP	Grade
Alabama	Ambetter of Alabama		D
	Blue Cross Blue Shield of Alabama	✓	
	UnitedHealthcare	✓	
Alaska	Premera Blue Cross Blue Shield of Alaska		C
	Moda Health Plan, Inc.	✓	
Arizona	Ambetter from Arizona Complete Health		A
	Antidote Health Plan of Arizona		
	Banner Health & Aetna Health Plan		
	Blue Cross Blue Shield of Arizona	*	
	Cigna HealthCare of Arizona	*	
	Imperial Insurance Companies	*	
	Oscar Health Plan, Inc.		
	UnitedHealthcare of Arizona		
Arkansas	Ambetter from Arkansas Health & Wellness	*	A
	Arkansas Blue Cross Blue Shield		
	Health Advantage		
	Octave		

✓ Plan has a CAAP

* Plan applies copay assistance for brand drug with no generic equivalent

+ Plan utilizes variable copay policy or third-party sourcing of specialty prescription drugs.

State	Issuer	CAAP	Grade
California	Aetna/CVS	✓	C
	Anthem Blue Cross of CA	✓	
	BlueShield of CA	✓	
	Balance by Chinese Community Health Plan		
	Health Net	✓	
	Inland Empire Health Plan		
	Kaiser Permanente		
	LA Care Health Plan		
	Molina	✓	
	Sharp Health	✓	
	Valley Health Plan		
	Western Health Advantage		
Colorado	Anthem	✓	C
	Cigna Healthcare	*	
	Denver Health Plan		
	Kaiser Permanente		
	Rocky Mountain Health Plans	✓	
	SelectHealth		
Connecticut	Anthem		A
	ConnectiCare Benefits		
	ConnectiCare Insurance Company Inc.		
Delaware	Aetna CVS Health		B
	Ambetter Health of Delaware		
	AmeriHealth Caritas Next	✓	
	Highmark Blue Cross Blue Shield Delaware		
District of Columbia	Kaiser		A
	CareFirst BlueCross BlueShield	*	

State	Issuer	CAAP	Grade
Florida	Ambetter Health from Sunshine underwritten by Celtic	*	F
	Aetna CVS Health	✓	
	AmeriHealth Caritas Next	✓	
	AvMed	✓	
	Capital Health Plan	✓	
	Cigna Healthcare	✓	
	Florida Blue HMO (Health Options)	✓	
	Florida Blue (BlueCross BlueShield)	✓	
	Florida Health Care Plan	✓	
	Health First Commercial Plans	✓	
	Molina Healthcare	*	
	Oscar Insurance Company of Florida	✓	
	UnitedHealthcare	✓	
	Wellpoint		
Georgia	Aetna CVS Health		B
	Alliant Health Plans		
	Ambetter from Peach State Health Plan	✓	
	Anthem Blue Cross and Blue Shield		
	CareSource		
	Cigna HealthCare of Georgia		
	Kaiser Permanente		
	Oscar Health Plan of Georgia		
	United Healthcare	✓	
Hawaii	HMSA		A
	Kaiser Permanente		

State	Issuer	CAAP	Grade
Idaho	Blue Cross of Idaho	✓	F
	Moda	✓	
	Molina	*	
	Mountain Health CO-OP	✓	
	PacificSource	✓	
	Regence BS	✓	
	SelectHealth	✓	
	St. Luke's Health Plan	✓	
Illinois	Aetna CVS Health	*	B
	Ambetter of Illinois		
	Blue Cross and Blue Shield of Illinois		
	Cigna Healthcare		
	Health Alliance		
	MercyCare Health Plans	✓	
	Molina Healthcare		
	Oscar Health Plan, Inc.		
	Quartz		
	UnitedHealthcare		
Indiana	Aetna CVS Health	✓	D
	Ambetter Health from MHS	*	
	Anthem Blue Cross and Blue Shield	✓	
	CareSource		
	Cigna Healthcare	✓	
	United Healthcare	✓	

State	Issuer	CAAP	Grade
Iowa	Ambetter Health	*	F
	Medica	✓	
	Oscar Insurance Company	✓	
	UnitedHealthcare	✓	
	Wellmark Health Plan of Iowa	✓	
Kansas	Aetna CVS	✓	D
	Ambetter from Sunflower Health		
	Blue Cross Blue Shield of Kansas	✓	
	Blue Cross Blue Shield of Kansas City	✓	
	Medica	✓	
	Oscar Insurance Company		
	UnitedHealthcare	✓	
Kentucky	Anthem Health Plans of KY		A
	Passport by Molina Healthcare	*	
	CareSource Kentucky Co.		
	Wellcare Health Plans of Kentucky, Inc. (Ambetter)	*	
Louisiana	Ambetter from Louisiana Healthcare Connections		B
	Blue Cross Blue Shield of Louisiana		
	Louisiana Blue		
	CHRISTUS Health Plan		
	UnitedHealthcare	✓	
Maine	Anthem		A
	Community Health Options		
	Harvard Pilgrim HealthCare		
	Taro	*	
Maryland	Aetna		C
	CareFirst BlueCross BlueShield (PPO)	✓	
	CareFirst BlueChoice (HMO)	✓	
	Kaiser Permanente		
	Wellpoint	✓	
	(Optimum Choice) UnitedHealthcare		

State	Issuer	CAAP	Grade
Massachusetts	Mass General Brigham		C
	BCBS of Mass		
	Fallon Community Health Plan		
	Harvard Pilgrim Health Care		
	Tufts Health Plans	✓	
	WellSense		
	United Healthcare	✓	
Michigan	Ambetter from Meridian		D
	Blue Care Network of Michigan	✓	
	Blue Cross Blue Shield of Michigan	✓	
	HAP CareSource		
	McLaren Health Plan Community	✓	
	Molina	*	
	Oscar Health	✓	
	Priority Health	✓	
	United HealthCare	✓	
	University of Michigan Health Plan	✓	
Minnesota (Regulation state)	BCBS Minnesota	✓	C
	Health Partners	✓	
	Medica		
	Quartz		
	UCare		
Mississippi	Ambetter from Magnolia Health		C
	Cigna Healthcare	✓	
	Molina Healthcare	*	
	Vantage Health Plan of MS (Primewell)		
	UnitedHealthcare	✓	

State	Issuer	CAAP	Grade
Missouri	Aetna CVS Health		F
	Anthem Blue Cross Blue Shield	✓	
	Ambetter from Home State Health	✓	
	BlueCross BlueShield of Kansas City	✓	
	Cox Health Systems Insurance Co.	✓	
	Medica	✓	
	Oscar Insurance Company	✓	
	UnitedHealthcare	✓	
Montana	Blue Cross and Blue Shield of Montana	✓	F
	Montana Health CO-OP	✓	
	PacificSource Health Plans	✓	
Nebraska	Ambetter from Nebraska Total Care		D
	Blue Cross and Blue Shield of Nebraska	✓	
	Medica	✓	
	Oscar Insurance Company	✓	
	UnitedHealthcare		
Nevada (Regulation state)	Aetna CVS Health		C
	*Ambetter from Silver Summit (Centene)		
	Anthem	✓	
	Health Plan of Nevada	✓	
	Hometown Health	✓	
	Molina		
	SelectHealth	✓	
	Imperial		
New Hampshire	Ambetter from NH Healthy Families	✓	C
	Anthem Blue Cross and Blue Shield	✓	
	Harvard Pilgrim Health Care		
	WellSense Health Plan	*	

State	Issuer	CAAP	Grade
New Jersey	Aetna CVS Health		B
	AmeriHealth Ins Company of NJ		
	Horizon Blue Cross Blue Shield of New Jersey	✓	
	Oscar		
	United HealthCare		
	WellCare (Ambetter)		
New Mexico	BlueCross BlueShield of New Mexico		A
	Molina Healthcare of New Mexico, Inc.		
	Presbyterian Health Plan		
	UnitedHealthcare of New Mexico, Inc.		
New York	Anthem		A
	CDPHP		
	Excellus BCBS	*	
	Emblem Health	*	
	Fidelis		
	HealthFirst		
	Highmark		
	Independent Health (IHBC)		
	MetroPlus		
	MVP Health		
	Oscar		
	United Healthcare		

State	Issuer	CAAP	Grade
North Carolina	Aetna CVS Health		
	Ambetter of North Carolina		
	AmeriHealth Caritas Next	✓	
	Blue Cross and Blue Shield of NC		
	CareSource		
	Cigna Healthcare		
	Oscar Health Plan of North Carolina, Inc		
	UnitedHealthcare	✓	
	Wellcare		
North Dakota	Blue Cross Blue Shield of North Dakota		C
	Medica	✓	
	Sanford Health Plan		
Ohio	AultCare Insurance Company	✓	D
	Ambetter from Buckeye Health Plan		
	Aetna CVS Health	✓	
	Anthem BlueCross and BlueShield	✓	
	Antidote Health Plan of Ohio		
	CareSource		
	MedMutual	✓	
	Molina Healthcare	*	
	Oscar Health Insurance	✓	
	Oscar Health Ins. Corp of Ohio	✓	
	Paramount	✓	
	SummaCare	✓	
	UnitedHealthcare	✓	

State	Issuer	CAAP	Grade
Oklahoma	Ambetter of Oklahoma		C
	Blue Cross and Blue Shield of Oklahoma		
	CommunityCare		
	Medica	✓	
	Oscar Insurance Company		
	Taro Health Plan		
	UnitedHealthcare	✓	
Oregon	BridgeSpan Health Company		B
	Kaiser Permanente		
	Moda Health Plan, Inc.	✓	
	PacificSource	*	
	Providence Health Plan		
	Regence BlueCross BlueShield of Oregon		
Pennsylvania	*Ambetter (PA Health & Wellness)		F
	*Capital BlueCross	✓	
	*Geisinger Health Plan (HMO)	✓	
	*Geisinger Quality Options, Inc. (PPO)	✓	
	*Highmark Blue Shield (PPO)(benefits group)	✓	
	Highmark Blue Cross Blue Shield	✓	
	*Highmark Inc.	✓	
	*Independence Blue Cross (keystone)	✓	
	*Jefferson Health Plans (health partners)	✓	
	*Oscar	✓	
	UPMC Health Plan	✓	
Rhode Island	BCBS	✓	C
	Neighborhood Health Plan of RI		

State	Issuer	CAAP	Grade
South Carolina	Ambetter from Absolute Total Care	✓	F
	BlueCross BlueShield of South Carolina	✓	
	Molina Healthcare	✓	
	InStil Health	✓	
	UnitedHealthcare	✓	
	First Choice Next by Select Health of SC		
South Dakota	Avera Health Plans	✓	D
	Sanford Health Plan		
	Wellmark of South Dakota	✓	
Tennessee	Alliant Health Plans		C
	Ambetter of Tennessee	*	
	BlueCross BlueShield of Tennessee	✓	
	Cigna Healthcare		
	Oscar Insurance Company		
	UnitedHealthcare	✓	
Texas	Aetna CVS Health		B
	Ambetter from Superior HealthPlan		
	Baylor Scott and White Health Plan		
	Blue Cross and Blue Shield of Texas		
	CHRISTUS Health Plan		
	Cigna Healthcare		
	Community First		
	Community Health Choice		
	Imperial Insurance Companies, Inc.	*	
	Moda Health, Inc.	✓	
	Molina Healthcare		
	Oscar Insurance Company		
	Sendero Health Plans, Local Nonprofit	✓	
	UnitedHealthcare		
	Wellpoint		

State	Issuer	CAAP	Grade
Utah	Aetna CVS Health	✓	F
	BridgeSpan Health Company	✓	
	Imperial Health Plan of Southwest	*	
	Molina Healthcare	✓	
	Regence BlueCross BlueShield of Utah	✓	
	SelectHealth	✓	
	University of UT Health Plans	✓+	
Vermont	BlueCross BlueShield of Vermont		A
	MVP Healthcare		
Virginia	Aetna CVS Health Inc.		B
	Anthem		
	CareFirst BlueCross BlueShield		
	Cigna Healthcare		
	Innovation Health Plan, Inc. (Aetna)		
	Kaiser Permanente		
	Oscar Insurance Company		
	Sentara Health Plans		
	UnitedHealthcare (Optimum)		

State	Issuer	CAAP	Grade
Washington	Ambetter (Coordinated Care)	*	B
	Asuris Northwest Health	*	
	BridgeSpan Health Company	*	
	Community Health Network of Washington		
	Kaiser Permanente		
	LifeWise Health Plan		
	Molina		
	Premera Blue Cross		
	Providence Health Plan		
	Regence BlueCross BlueShield	*	
	Regence BlueShield	*	
	UnitedHealthcare	✓	
West Virginia	CareSource		A
	Highmark Blue Cross Blue Shield West Virginia		
Wisconsin	Aspirus Health Plan	✓	F
	Anthem Blue Cross and Blue Shield	✓	
	Chorus Community Health Plan	✓	
	Common Ground Healthcare Cooperative	✓	
	Dean Health Plan		
	Group Health Cooperative - SCW	✓	
	HealthPartners	✓	
	Medica	✓	
	MercyCare Health Plans		
	Molina Healthcare	✓	
	Network Health	✓	
	Quartz Health Benefits	✓	
	Security Health Plan	✓	
	UnitedHealthcare	✓	
Wyoming	BCBS of Wyoming	✓	F
	United Healthcare	✓	
	Mountain Health CO-OP	✓+	

Appendix 2: How Copay Accumulators Work

Copay assistance represents a small but important share of overall pharmaceutical claims. By one estimate, copay assistance was used for 3.4% of prescriptions filled between 2013 and 2017 in commercial health plans.[1] These prescriptions are generally for specialty medications that are prescribed to treat serious, complex chronic illness such as HIV, cancer, epilepsy, multiple sclerosis, and hemophilia. Only 0.4% of those prescription drugs had a generic equivalent (which is also likely to be designated as a specialty medication).

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 may have to pay their entire deductible (again) before they can get their prescription. Their pharmacy bill could run as high as several thousand dollars. Many patients cannot afford that and walk away empty-handed. In fact, recent research 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.[2] 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 (below) is a simplified overview of how copay accumulator adjustment policies work for patients who use copay assistance.

Example 1

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

Without a 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.

With a 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.

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

[2] 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.

Example 2 (following page) shows how copay accumulator adjustment policies change what patients pay out of pocket and what insurers collect throughout the year. In Scenario 1, the patient's plan does not have a copay accumulator adjustment policy. The patient is enrolled in a copay assistance program that provides an annual allotment of $7,200 for a drug with a list price of $1,680 per month. The copay assistance covers the cost of the drug until the patient reaches their annual deductible (in March), and then it covers the coinsurance for which the patient is responsible (50% of the drug's list price, or $840). In July, there is only $80 left of copay assistance, leaving the patient with a bill for $760 to refill their prescription. In August, the patient must pay $590, which is the amount remaining before they hit their plan's annual out-of-pocket limit ($8,550), and the insurer/PBM has collected the full $8,550.

Scenario 2 shows the same patient with the same drug and the same plan, but this time the plan includes a copay accumulator adjustment policy. The presence of a copay accumulator adjustment policy nearly doubles the amount that the insurer/PBM collects: $15,160 instead of $8,550 – an increase of $7,960. The figures shown in these scenarios would vary depending on the price of the medication, the amount of copay assistance available to the patient, and the plan's annual deductible and copay amounts. What would not change is that when a plan includes a copay accumulator adjustment policy, patients are faced with significantly higher out-of-pocket costs that, if they are able to pay them, are collected by the insurer and/or PBM.[3]

[3] Prescription Costs, Health Plan Design, and Copay Assistance Tables: These scenarios do not take into account the discounted price that the insurer pays for the drug. Because they are bulk purchasers, insurers work with Pharmacy Benefit Managers (PBMs) to negotiate discounts with the drug manufacturers. The only purchasers who pay list price for a drug are patients. They also do not take into account any cost-sharing that the patient has paid for other drugs or other health care services during the year.

Example 2

- 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**
Patient Pays	$0	$0	$0	$0	$0	$0	$760	$590	$0	$0	$0	$0	$1,350	

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**
Patient 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

Appendix 3: State Laws Banning Copay Diversion Policies

State	Copay Accumulator Language
West Virginia HB.2770 2019	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.
Virginia SB.1596 2019	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.
Arizona HB.2166 2019	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.
Illinois HB.0465 2019	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.
Georgia SB.313 2020	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.

State	Copay Accumulator Language
Kentucky SB.45 2021	To the extent permitted under federal law, an insurer issuing or renewing a health plan on or after the effective date of this Act, or a pharmacy benefit manager, shall not: (a) Require an insured purchasing a prescription drug to pay a cost-sharing amount greater than the amount the insured would pay for the drug if he or she were to purchase the drug without coverage. (already in statue prior to SB 45) (b) Exclude any cost-sharing amounts paid by an insured or on behalf of an insured by another person for a prescription drug, including any amount paid under paragraph (a) of this subsection, when calculating an insured's contribution to any applicable cost-sharing requirement. The requirements of this paragraph shall not apply in the case of a prescription drug for which there is a generic alternative, unless the insured has obtained access to the brand prescription drug through prior authorization, a step therapy protocol, or the insurer's exceptions and appeals process.
Oklahoma HB.2678 2021	Any of the following acts by an insurer, if committed in violation of Section 1250.3 of this title, constitutes an unfair claim settlement practice exclusive of paragraph 16 of this section which shall be applicable solely to health benefit plans: 18. As a health insurer that provides pharmacy benefits or a pharmacy benefits manager that administers pharmacy benefits for a health plan, failing to include any amount paid by an enrollee or on behalf of an enrollee by another person when calculating the enrollee's total contribution to an out-of-pocket maximum, deductible, copayment, coinsurance or other cost-sharing requirement.
Arkansas HB.1569 2021	(b)(1) When calculating an enrollee's contribution to any applicable cost-sharing requirement, a healthcare insurer shall include any cost-sharing amounts paid by the enrollee or on behalf of the enrollee by another person. (2) The cost-sharing requirement under subdivision (b)(1) of this section does not apply for cost-sharing of a prescription drug if a name-brand prescription drug is prescribed and the prescribed drug: (A) Is not considered to be medically necessary by the prescriber; and (B) Has a medically appropriate generic prescription drug equivalent.

State	Copay Accumulator Language
Tennessee HB.619 2021	(a) When calculating an enrollee's contribution to an applicable cost sharing requirement, an insurer shall include cost sharing amounts paid by the enrollee or on behalf of the enrollee by another person. (b) Subsection (a) does not apply to a prescription drug for which there is a generic alternative, unless the enrollee has obtained access to the brand name prescription drug through prior authorization, a step therapy protocol, the insurer's exceptions and appeals process, or as specified in § 53-10-204(a).
Connecticut SB.1003 2021	Sec 4) and 5) When calculating an enrollee's liability for a coinsurance, copayment, deductible or other out-of-pocket expense for a covered benefit, give credit for any discount provided or payment made by a third party for the amount of, or any portion of the amount of, the coinsurance, copayment, deductible or other out-of-pocket expense for the covered benefit.
Louisiana SB.94 2021	B. When calculating an enrollee's contribution to any applicable 30 cost-sharing requirement, a health insurance issuer shall include any cost-sharing amounts paid by the enrollee or on behalf of the enrollee by another person.
North Carolina SB.257 2021	(c1) When calculating an insured's contribution to any out-of-pocket maximum, deductible, copayment, coinsurance, or other applicable cost-sharing requirement, the insurer or pharmacy benefits manager shall include any amounts paid by the insured, or on the insured's behalf, for a prescription that is either: (1) Without an AB-rated generic equivalent. (2) With an AB-rated generic equivalent if the insured has obtained authorization for the drug through any of the following: a. Prior authorization from the insurer or pharmacy benefits manager. b. A step therapy protocol. c. The exception or appeal process of the insurer or pharmacy benefits manager.

State	Copay Accumulator Language
Washington SB.5610 2022	Except as provided in (b) of this subsection, when calculating an enrollee's contribution to any applicable cost-sharing or out-of-pocket maximum, a health carrier offering a non-grandfathered health plan with a pharmacy benefit, or a health care benefit manager administering benefits for the health carrier, shall include any cost-sharing amounts paid by the enrollee directly or on behalf of the enrollee by another person for a covered prescription drug that is: without a generic equivalent or with a generic equivalent that is preferred by the plan's formulary or enrollee has gained accessed via exceptions process and utilization management. This section does not apply to a qualifying health plan for a health savings account to the extent necessary to preserve the enrollee's ability to claim tax exempt contributions and withdrawals from the enrollee's health savings account under internal revenue service laws, regulations, and guidance.
Maine LD.1783 2022	When calculating a covered person's contribution to any applicable cost-sharing or other out-of-pocket expense under a covered prescription drug benefit, a carrier or PBM shall give credit for any waiver, discount provided or payment made by a 3rd party for the amount of, or any portion of the amount of, the applicable cost-sharing or other out-of-pocket expense for the covered prescription drug benefit. The requirements of this subsection do not apply in the case of a prescription drug for which there is a generic alternative, unless the covered person has obtained access to the brand-name drug through prior authorization, a step therapy override exception or other exception or appeal process.

State	Copay Accumulator Language
Delaware SB.267 2022	(d) Cost-Sharing Calculation. When calculating an enrollee contribution to any applicable cost sharing requirement, a carrier shall include any cost-sharing amounts paid by the enrollee or on behalf of the enrollee by another person. If under federal law, application of this requirement would result in Health Savings Account ineligibility under § 223 of the federal Internal Revenue Code, this requirement shall apply for Health Savings Account-qualified High Deductible Health Plans with respect to the deductible of such a plan after the enrollee has satisfied the minimum deductible under § 223, except with respect to items or services that are preventive care pursuant to § 223(c)(2)(C) of the federal Internal Revenue Code, in which case the requirements of this paragraph shall apply regardless of whether the minimum deductible under § 223 has been satisfied.
New York A.1741 2022	Section 1 requires any individual insurance policy that provides coverage for prescription drugs to apply any third-party payments or other price reduction instruments for out-of-pocket expenses made on behalf of an insured person when calculating the insured individuals overall contribution to any out-of-pocket maximum or cost-sharing requirement.
New Mexico SB.51 2023	When calculating an insured's cost-sharing obligation for covered prescription drugs, pursuant to an individual or group health insurance policy, health care plan or certificate of health insurance that is delivered, issued for delivery or renewed in this state, the insurer shall credit the insured for the full value of any discounts provided or payments made by third parties at the time of the prescription drug claim. The provisions of this section do not apply to excepted benefit plans as provided pursuant to … high-deductible health plans with HSAs until an eligible insured's deductible has been met, unless otherwise allowed pursuant to federal law.

State	Copay Accumulator Language
District of Columbia DC.B25 2023	When calculating a member's contribution to their coinsurance, copayment, cost-sharing responsibility, deductible, or out-of-pocket maximum under the member's health benefit plan, the health insurer shall include any discount, financial assistance payment, product voucher, or any other out-of-pocket expense made by or on behalf of the member for a prescription drug covered under the member's health benefit plan that: "(1) Is without a generic drug equivalent or an interchangeable biological product preferred under the health benefit plan's formulary; or "(2) Has a generic equivalent drug or an interchangeable biological product preferred under the health benefit plan's formulary where the member has obtained access to the drug through prior authorization, a step therapy protocol, or the exception or appeal process of the health insurer or pharmacy benefits manager.
Colorado SB.23 2023	When calculating a covered person's overall contribution to an out-of-pocket maximum or cost-sharing requirement under the covered person's health benefit plan, a carrier or pbm shall include any amount paid by the covered person or by another person on behalf of the covered person for a prescription drug if: (i) the prescription drug does not have a generic equivalent or, for a prescription drug that is a biological product, the prescription drug does not have a biosimilar drug, as defined in 42 u.s.c. Sec. 262 (i)(2), or an interchangeable biological product, as defined in 42 u.s.c. Sec. 262 (i)(3); or (ii) the prescription drug has a generic equivalent, a biosimilar drug, or an interchangeable biological product, and the covered person is using the brand-name prescription drug.

State	Copay Accumulator Language
Texas HB.999 2023	An Act relating to the effect of certain reductions in a health benefit plan enrollee's out-of-pocket expenses for certain prescription drugs on enrollee cost-sharing requirements. This section applies only to a reduction in out-of-pocket expenses made by or on behalf of an enrollee for a prescription drug covered by the enrollee's health benefit plan for which: (1) a generic equivalent does not exist; (2) a generic equivalent does exist but the enrollee has obtained access to the prescription drug under the enrollee's health benefit plan using:(A) a prior authorization process;(B) a step therapy protocol; or (C) the health benefit plan issuer's exceptions and appeals process; (3) an interchangeable biological product does not exist; or (4) an interchangeable biological product does exist but the enrollee has obtained access to the prescription drug under the enrollee's health benefit plan using:(A) a prior authorization process;(B) a step therapy protocol; or(C) the health benefit plan issuer's exceptions and appeals process.
Oregon HB.4113 2024	To the extent permitted by federal law, an insurer offering a health plan that provides pharmacy benefits and a pharmacy benefit manager shall include all amounts paid by an enrollee or paid by another person on behalf of an enrollee toward the cost of a covered prescription drug when calculating the enrollee's contribution to an out-of-pocket maximum, deductible, copayment, coinsurance or other cost-sharing requirement applied to the drug if: (a) The drug does not have a generic equivalent; or (b) The drug has a generic equivalent and the enrollee has: (A) Obtained prior authorization from the insurer or pharmacy benefit manager; (B) Complied with a step therapy protocol; or (C) Received approval from the insurer or pharmacy benefit manager through the insurer's or the pharmacy benefit manager's exceptions, appeal or review process. For high deductible health plans, this subsection apply only to preventive services until the enrollee has satisfied the minimum deductible under 26 U.S.C. 223(c)(2).

State	Copay Accumulator Language
Vermont H.233 2024	A pharmacy benefit manager shall attribute any amount paid by or on behalf of a covered person, including any third-party payment, financial assistance, discount, coupon, or any other reduction in out-of-pocket expenses made by or on behalf of a covered person for prescription drugs, toward the out-of-pocket limits for prescription drug costs, the covered person's deductible, and the annual out-of-pocket maximums. The provision shall only apply to a prescription drug: (i) for which there is no generic drug or interchangeable biological product, or (ii) for which there is a generic drug or interchangeable biological product, but for which the covered person has obtained access through prior authorization, a step therapy protocol, or the pharmacy benefit manager's or health benefit plan's exceptions and appeals process. The provisions shall apply to a high-deductible health plan only to the extent that it would not disqualify the plan from eligibility for a health savings account pursuant to 26 U.S.C. § 223.
Puerto Rico S.1658 2020	Any health insurance organization or insurer that provides prescription drug benefits, a pharmacy provider or benefits manager shall include in the calculation or requirement of cost sharing or out-of-pocket maximum, any payment, discount, or item that is part of a financial assistance program, discount plan, coupon, 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 provider, in accordance 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 subparagraph is prohibited.

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