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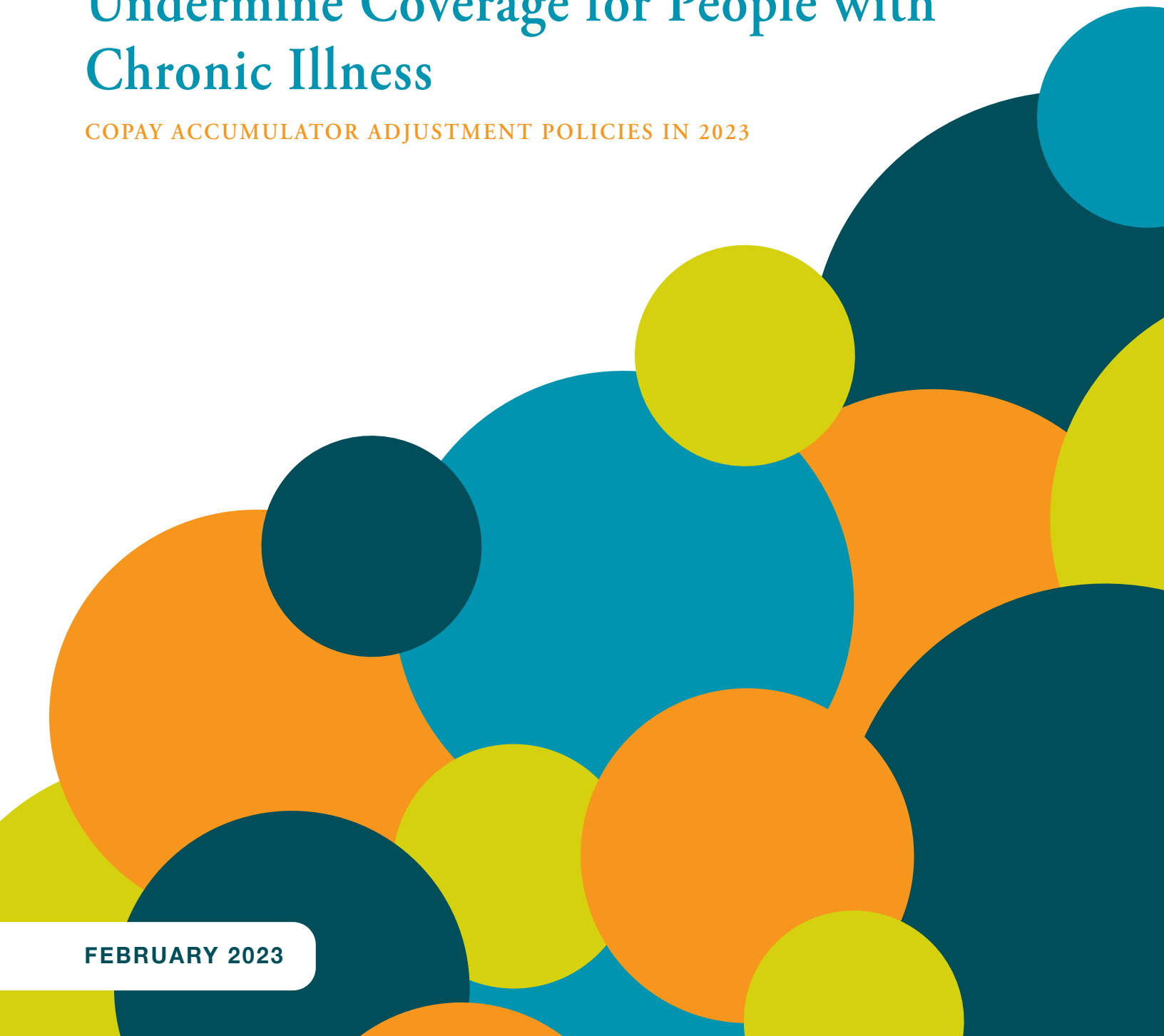
Discriminatory Copay Policies Undermine Coverage for People with Chronic Illness

COPAY ACCUMULATOR ADJUSTMENT POLICIES IN 2023



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Introduction

Patients with rare, complex, or chronic diseases such as HIV and viral hepatitis often need high-cost medications to manage their conditions and maintain their health. For many of these medications, there is no generic or less expensive alternative. Over the past decade, insurance companies and pharmacy benefit managers (PBMs) have increasingly required patients with chronic illness to bear more of the cost of their care through higher deductibles and copayments (the amounts that people with health insurance have to pay when they get health care). For many people with chronic illness, these amounts have become too high to afford the medications they need, *even when they have insurance*.

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

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

Unfortunately, the federal government has allowed copay accumulator adjustment policies to flourish, despite outcries from patients struggling to afford the prescription drugs they need to get and stay healthy. A rule finalized in the last year of the Trump administration allows health insurance companies and PBMs to use copay accumulator adjustment policies at their discretion, even where there is no medically appropriate generic drug available. Despite President Biden's Executive Order directing the Department of Health and Human Services (HHS) to review policies that could pose barriers to health care, HHS has not yet reversed that decision.

Copay accumulator adjustment policies add extra costs for patients who have serious, complex, chronic illnesses, making it harder for these patients to afford the medicines they need, compounding the economic burden millions of Americans are experiencing as they struggle to afford basic necessities like rent, gas, and groceries. Unexpected costs due to copay accumulator adjustment programs only increase this financial strain and jeopardize vulnerable patients' health. In an attempt to protect patients from this harm, 16 states now have laws that prevent the practice.

This report examines how widely insurance companies and PBMs have adopted these policies in the health insurance plans they offered to individuals and families in the health insurance marketplace for 2023. We found that use of these policies is widespread, undermining access to essential and life-saving medicines for patients with health insurance.

This report covers:

- Overview of Our Methodology
- Findings
- How Copay Assistance Works with Copay Accumulator Adjustment Policies
- Cost-sharing and Plan Design Pose Barriers to Health Care
- The Impact of Copay Accumulator Adjustment Policies on Patients
- Federal Regulation and Legislation Regarding Copay Accumulator Adjustment Policies
- State Actions to Protect Patients' Access to Prescriptions
- Conclusion

Overview of Our Methodology

Copay accumulator adjustment policies can have an enormous impact on whether patients with HIV, AIDS, viral hepatitis, or other serious or chronic illnesses can afford their medicines. To find out how common these policies are and how they affect patients' insurance, The AIDS Institute conducted original research, reviewing individual market health plans across all states and the District of Columbia for 2023.[1] We did not review plans in the 16 states with laws that require insurance companies to count copay assistance toward enrollees' deductibles and out-of-pocket limits. We examined all available policy documents from all insurers that offered plans in the remaining states, 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.

Findings

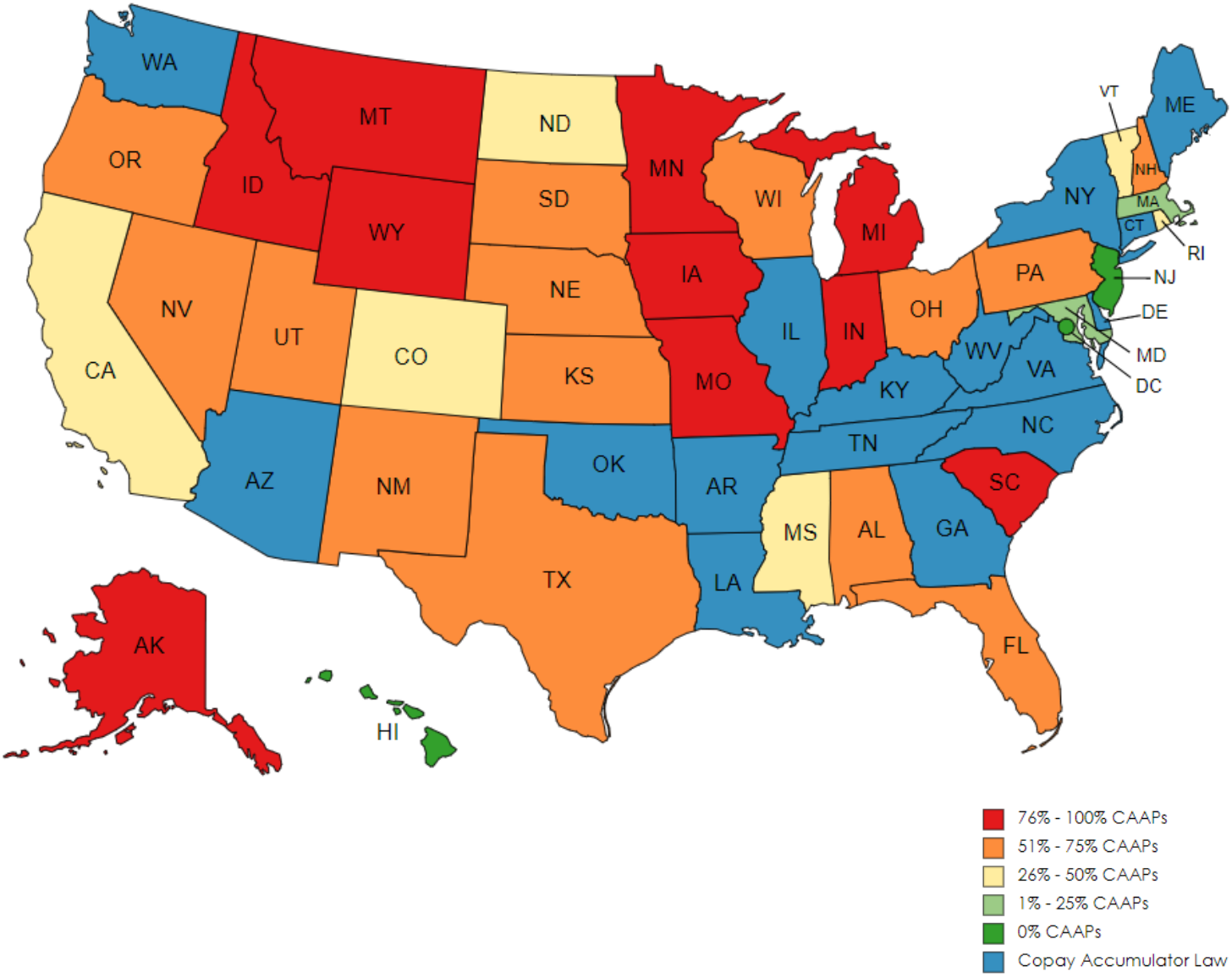
Our review of health insurance plans offered to individuals and families through the ACA marketplaces for 2023 found that copay accumulator adjustment policies are widespread.

- Nationwide, almost **two-thirds** (64%) of all individual health plans available on the marketplace include CAAPs. But there is wide variation from state to state.
- In **18** states and **Washington DC**, zero plans include CAAPs, ensuring that enrollees' copay assistance is used for its intended purpose. These states scored a **Grade A** for 2023.[2]
  - In **16** states plus Puerto Rico, state law prohibits CAAPs in 2023 (AR, AZ, CT, DE, GA, IL, KY, LA, ME, NC, NY, OK, TN, VA, WA, WV).[3]
  - In **2** states and **DC**, all plans voluntarily opted not to include CAAPs (HI, NJ).
- In **32** states, there is **at least one plan** with a copay accumulator adjustment policy.[4]
  - In **2** states, **25%** of available plans have a copay accumulator policy (MA, MD). These states earned a **Grade B** for 2023.
  - In **6** states, between **25% and 50%** of plans include a CAAP (CA, CO, MI, ND, RI, VT). These states earned a **Grade C** for 2023.
  - In **14** states, **50% to 75%** of available plans include a CAAP (AL, FL, KS, NE, NH, NM, NV, OH, OR, PA, SD, TX, UT, WI). These states earned a **Grade D** for 2023.
  - In **10** states, **75% to 100%** of plans include a copay accumulator adjustment policy: (AK, IA, ID, IN, MI, MN, MO, MT, SC, WY). These states earned a **Grade F** for 2023.
- Information about CAAPs is confusing and difficult for enrollees to find.
- Insurers and PBMs are not required to make information about CAAPs clear for patients shopping for coverage. Our research found that this information is difficult to locate and is often written in confusing language. People shopping for coverage may need to call specific insurers to learn about any copay accumulator adjustment policies if the information is not available in plan materials. However, customer service representatives often do not know 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.

- Overall, **28** plans in the states we researched did not share information about whether they had a copay accumulator policy in plan materials that were available to people before enrollment.[5] Of those, **13** plans do have a copay accumulator adjustment policy.[6]
- More plans included information about copay accumulator adjustment policies in their materials for 2023 plans than they did in their materials for 2022.
- Insurer and PBM policies regarding copay assistance continue to evolve. For the first time, we found insurance issuers and PBMs employing variations on CAAPs sometimes referred to as "copay maximizers" or "variable copay programs" designed to ensure that the insurer captures as much financial assistance from pharmaceutical manufacturers or charitable assistance funds as possible without benefiting patients.[7] We found these policies in plans in **7** states in 2023 (ID, MO, MT, NE, PA, WY, and UT).

Percent of 2023 ACA Plans with Copay Accumulator Policies



How Copay Assistance Works with Copay Accumulator Adjustment Policies

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.[8] 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.[9]

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.

Example 2 (following page) shows how copay accumulator adjustment policies change what patients pay out of pocket and what insurers collect. 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 has the impact of nearly doubling 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.[10]

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

Copay Maximizers vs. Copay Accumulator Adjustment Policies

Instead of a copay accumulator, some plans include policies referred to as "copay maximizer programs", or "variable copay programs". These policies have previously been used in large employer-sponsored insurance plans rather than those available for individuals and small groups in the health insurance marketplace. However, our research identified plans that include maximizer program language for the first time in 2023 plans.

Copay maximizer programs differ from copay accumulator adjustment policies in that they require patients to enroll in available manufacturer copay assistance programs and set patient copay amounts for those medications at the maximum amount of copay assistance that is available for a given drug rather than as a flat dollar amount or share of the list price of the drug. In a copay maximizer program, the copay assistance is similarly not counted toward the patient's annual deductible or out-of-pocket limit. While that may not impact their ability to refill that particular medication in the same way that a copay accumulator policy does, it also means that patients remain subject to the deductible and cost-sharing for any other medications or health care services that they may need during the year.

In some iterations of a copay maximizer program, the insurer and/or PBMs declare specialty medications as "non-essential health benefits" under the plan. When a prescription or health service is deemed non-essential, no payments will be applied toward the deductible or out-of-pocket maximum.[11] The plan pairs this policy with a copay maximizer program to ensure specialty copay assistance is still taken advantage of by the insurer or PBM.

Cost-Sharing and Plan Design Pose Barriers to Health Care

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

These insurance design issues and cost-sharing structure make it difficult for insured people who need health care to know how their insurance works and to afford the care they need.

Insurance Is (Still) Complicated

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

Shifting More of the Burden to Patients

Over time, insurers have changed the structure of health insurance benefits to shift more costs to patients. For example, insurers have raised deductibles, added new prescription drug tiers and increased the use of coinsurance for higher tiers, and instituted "utilization management" measures.

Deductibles and Out-of-Pocket Limits

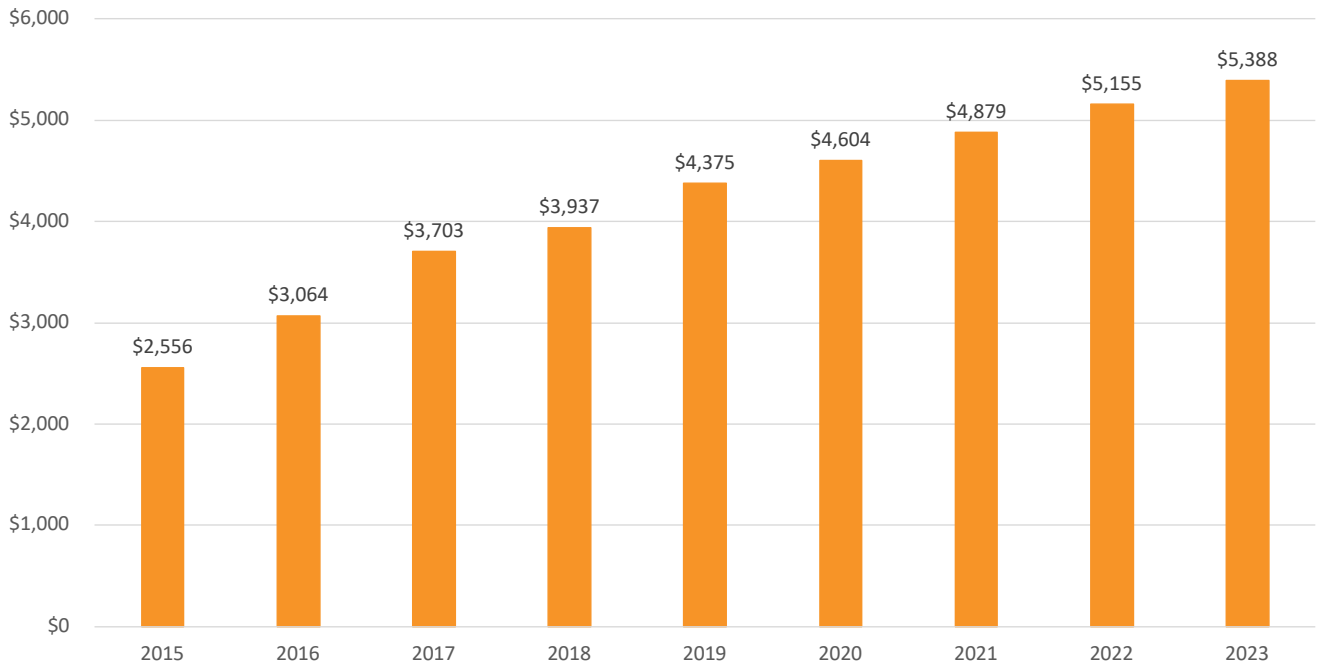
Deductibles can pose a significant barrier to care for people living with chronic illness. The Consumer Financial Protection Bureau (CFPB) estimates that 40% of American households experienced difficulty paying their monthly bills in at least one month in 2022.[12] As individuals and families evaluate their budgets, plans with lower monthly premiums may be appealing to shoppers; however, those plans come with very high deductibles and studies have shown that enrollees in high-deductible health plans (HDHPs) often delay or forego care due to their inability to meet the high deductible.[13,14]

In 2023, the average deductible for a silver plan, the most popular level of health plans that offer mid- range coverage, is $5,388, more than double the average deductible of $2,556 in 2015.[15,16] But many people may be enrolled in plans with even higher deductibles: deductibles can be as high as the annual out-of-pocket limit for the year: $9,100 for an individual and $18,200 for a family in 2023.[17,18] Example 3 (following page) shows how deductibles have more than doubled since 2015.

The ACA did include some policies to alleviate the financial burden on very low-income enrollees and prevent more people from experiencing medical debt. Cost-sharing reductions (CSRs) reduce deductibles, copayments, and other out-of-pocket expenses for eligible enrollees with incomes below 250% of the federal poverty level.

Example 3

Change in the Average Deductible for Individual Market Plans 2015-2023



Unfortunately though, based on federal poverty levels for 2023, individuals making $36,451 or more per year would not qualify for the benefits of CSRs: that includes almost half of all individuals who purchase their insurance from the HealthCare.gov.[19]

The maximum out-of-pocket limit, like deductibles, is also increasing every year.

The annual out-of-pocket limit is intended to provide financial protection for people who have high health care costs, like those with chronic conditions. The annual out-of-pocket limit is projected to increase from $9,100 for an individual in 2023 to $9,500 in 2024. The annual limit is growing at a faster rate than wages and is reaching a point that no longer offers meaningful financial protection.[20]

Most enrollees will never hit an out-of-pocket limit of $9,100; people managing a chronic illness requiring specialty medications may be forced to pay this amount every single year, often in the first few months of the year.[21, 22] Since most Americans do not have an extra $9,100 after they pay their health insurance premium, rent or mortgage, food, transportation, childcare, and other basic needs, copay assistance is often the only way they can afford the medication they need, even if they have insurance.[23]

Prescription Drug Tiers That Use Coinsurance

More plans now have four or more prescription drug formulary tiers. In 2019, 84% of silver plans in the marketplace (the most popular plans) used a specialty drug tier.[24] Health insurers place many of the drugs used to treat complex diseases such as HIV, hemophilia, arthritis, and epilepsy in the highest or specialty tiers. Higher formulary tiers often use coinsurance (a percentage of the drug's list price) rather than copayments (a fixed dollar amount). And since these tiers have higher cost-sharing, plans with more tiers require patients to pay more out of pocket.[25]

It is very common for insurers to charge coinsurance of 30-50% for higher tiers. One group of researchers found that the vast majority (81%) of silver level individual market plans required enrollees to pay coinsurance for specialty drugs, and just 12% cover any specialty drugs before the deductible is met.[26] The median coinsurance amount for the 69% of silver plans using coinsurance post-deductible was 40%. That 40% could translate to thousands of dollars a month for a patient with a chronic condition. And because coinsurance is based on the list price rather than the discounted price the insurer pays for prescription drugs, patients are paying significantly more of the cost of their medication than the coinsurance percentage might indicate.

CMS reintroduced standardized plan options in 2023, which require all insurers to offer plans with deductibles and cost-sharing benefits that are consistent with HHS regulations for each metal level.[27] These standardized plans establish copayments for four tiers of prescription drugs: generic, preferred brand, non-preferred brand, and specialty drugs, and do not include an option for coinsurance.

The copayment amounts for specialty medications in standardized plans range from $150 per month per drug (platinum plans) to $500 per month per drug (bronze plans). For a standardized silver level plan (the most popular plan chosen by enrollees who buy insurance in the marketplace, specialty drugs are assigned a $350 copayment, after the patient has paid the $5,800 deductible.[28] Table 1 (below) shows how much the deductible and prescription drug copayments are in the different standardized plans.

The shift to a flat dollar copayment amount will help reduce what many people must pay for specialty medications, but advocates remain concerned that the copayment amounts for specialty drugs is still too high for most people with chronic illness to afford, and does not eliminate the affordability gap filled by copay assistance.

Table 1

- Standardized Plan Cost Sharing

	Bronze	Non-CSR Silver	Gold	Platinum
Deductible	$7,500	$5,800	$2,000	$0
Generic Rx	$25*	$20*	$15*	$5*
Preferred Brand Rx	$50	$40*	$30*	$10*
Non-Preferred Brand Rx	$100	$80	$60*	$50*
Specialty Rx	$500	$350	$250*	$150*
Annual OOP Limit	$9,000	$8,900	$8,700	$3,000

*Copay amounts are not subject to the deductible.

Utilization Management

Insurers and pharmacy benefit managers do not rely just on cost to deter patients from expensive treatments. They also employ "utilization management tools," such as limited formularies, step therapy, generic substitution, prior authorization, and pill quantity limits to control what treatments they pay for. Patients who are ultimately prescribed more expensive treatments have generally exhausted all other options, gaining the insurer and/or pharmacy benefit manager's approval to use them because less expensive options did not work or were not medically appropriate for them. It is only at this stage – when the insurer and/or PBM has approved access to a specialty medication – that patients turn to copay assistance to help cover their share of the cost for the treatment.[29]

The Impact of Copay Accumulator Adjustment Policies on Patients

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

For many diseases, like HIV and hepatitis C, there are no generic alternatives to brand-name medications. In addition, even when generics are available, they are still often prohibitively expensive and unaffordable for patients. For example, a generic drug that came on the market in 2018 to treat multiple sclerosis (MS) was priced 20% lower than the brand-name drug – at approximately $60,000 a year.[30]

High monthly costs make it more likely that patients will stop taking their medications, which could seriously worsen their health over the long term. One survey found that among people who said they did not take their medication as prescribed because of its cost, 20% did not fill a prescription, and another 12% skipped doses or cut pills in half to extend their supply.[31]

Not following a prescribed treatment regimen for a complicated health condition can lead to dangerous health consequences, such as irreversible worsening of their disease, hospitalization or becoming resistant to the drug. Another patient experience survey revealed that of the individuals who experienced an interruption to their prescription drug adherence, 82% of patients with infectious diseases like HIV reported negative health outcomes.[32]

Even delaying treatment temporarily can have a dramatic impact on a patient's long- term health and end up costing the health care system more in emergency room visits or additional medical treatment. And during the ongoing coronavirus pandemic, hospitals

across the nation have, at times, been unable to ensure that they can provide care for non-COVID patients who need hospitalization.[33]

How much does a patient have to pay for their medicine before they opt to leave their prescription at the counter? That amount is relatively low. Recent research on medication adherence 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.[34]

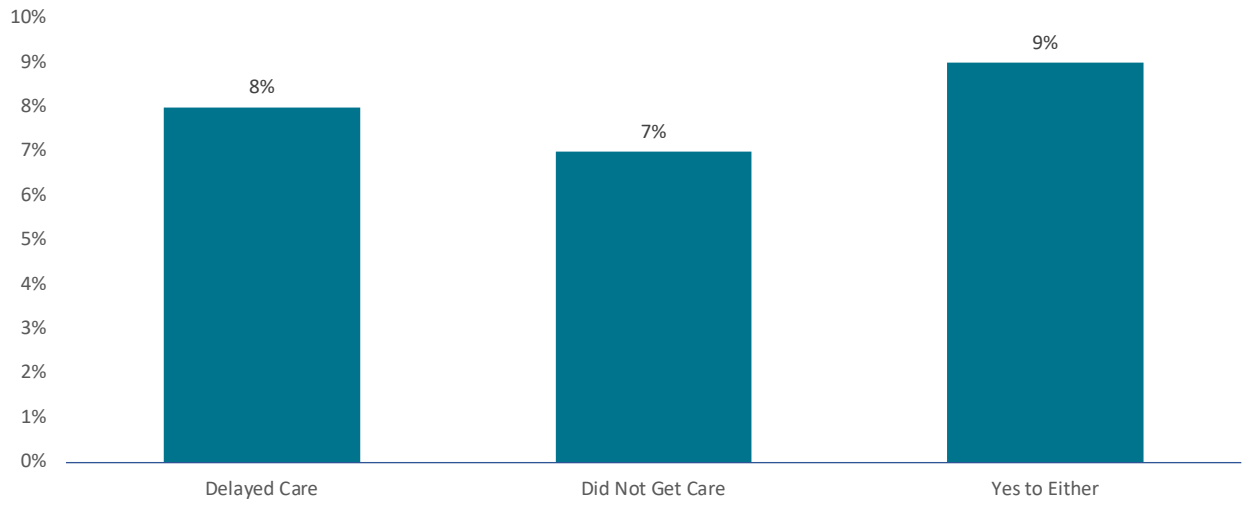
Copay assistance ensures that patients with expensive, chronic conditions can afford their medicines even with the growing out-of-pocket costs that insurers require. Copay accumulator adjustment policies remove that safety net.

Medical Debt

Copay accumulators not only put patients' physical health at risk, but they also threaten the financial well-being of patients, adding to the burden of already-high cost-sharing. Medical debt is a major concern for many individuals and families, and especially those with serious chronic conditions who have

Example 4

Percent of adults reporting delaying or going without care due to costs, 2020



high health care needs. In 2019, 17% of households (23 million people) had medical debt of $250 or more, 16 million people owed over $1,000, and 3 million people owed more than $10,000 in medical debt.[35]

Other research has found that people of color, people with lower incomes, and people with chronic illness are more likely to be in medical debt.[36] One study showed that 27% of black households had medical debt, while 16.8% of non-black households had medical debt;[37] and another survey revealed that 34% of people with a chronic condition vs. 23% of those without a chronic condition report facing untenable medical bills.[38] Reducing medical debt is a matter of health equity.

The consequences of medical debt are serious. Most people do not have the savings or quick access to money to pay for the high cost of health insurance. In an analysis of The Survey of Consumer Finances, researchers detailed that for single-individual households, the median liquid assets (funds that can be converted to cash such as checking or savings accounts, certificates of deposits, or savings bonds) totaled $2,977.[39] Furthermore, 45% of single-person households do not have $2,000. Nearly one in five adults with health care related debt do not think they will ever be able to pay it off, and many report making significant sacrifices like delaying college, forgoing payment on other bills, or changing their housing as a result.[40] The cost-sharing required for health plans far exceeds individuals' financial capacity. A minor emergency or an unexpected medical bill, like what a patient might receive when a copay accumulator is in place, can push a patient easily into medical debt.

Copay Accumulator Adjustment Policies Can Also Harm People with Employer-Sponsored Insurance

While The AIDS Institute focused on insurers in the individual market because information on their health plan policies is more accessible, copay accumulator adjustment policies are also prevalent in employer-sponsored health plans. Almost half (49.6%) of Americans who have health insurance are covered by employer-sponsored health insurance.[41] Therefore, decisions made by employers about pharmacy benefit design have the potential to affect a much greater number of people.

With employers concerned about rising health care expenditures, they have increasingly turned to cost control mechanisms. A 2019 survey of a sample of large employers found that 34% were already using copay accumulator adjustment policies, and an additional 4% sought to add them in the next year – a significant increase over previous years.[42] The three largest pharmacy benefit managers (PBMs) are now marketing copay accumulator adjustment policies to employers that are designing their insurance plans,[43] which may be contributing to their increasing prevalence. However, the decision of how to balance reduced costs and employees' health is ultimately up to employers.

An additional reason to be concerned about copay accumulator adjustment policies in employer-sponsored health insurance plans is that most of the large plans do not have to follow state insurance laws. Therefore, even in states that have banned copay accumulator programs, a significant number of residents may still be enrolled in health insurance plans that have such programs.[44]

It will take federal regulatory or legislative action to completely protect people from copay accumulator policies and copay maximizer programs.

Federal Regulation and Legislation Regarding Copay Accumulator Adjustment Policies

The federal government has taken multiple positions on copay accumulator adjustment policies over the past few years in its annual "Notice of Benefit and Payment Parameters," (NBPP) which governs all private health insurance subject to the Affordable Care Act.[45]

The 2020 rule significantly restricted the ability of insurers to use copay accumulator adjustment policies except in very limited circumstances, allowing the practice only for specialty drugs that have a medically-appropriate generic equivalent.[46] While a broad ban on all copay accumulator adjustment policies would have provided the best patient protection, this final rule was still a significant win for patients and patient advocates.

However, before the rule went into effect, HHS announced that it would delay enforcement until 2021.[47] The final 2021 Notice of Benefit and Payment Parameters officially reversed HHS' original stance on patient copay assistance: The notice permitted insurers to use copay accumulator adjustment policies whenever they want without restrictions.[48] Furthermore, the final rule removed the protection for copay assistance in cases where no medically appropriate generic

drug is available. This was a devastating blow to patient access and put those who rely on specialty medications in a precarious position.

HHS' rationale for reversing course on copay accumulator adjustment policies is complicated. It defers to the IRS, which contends that the rule conflicted with an IRS policy prohibiting the use of pharmacy coupons or discounts for people who have a Health Savings Account (HSA) paired with a high-deductible health plan.[49] That IRS policy says that people who have an HSA must pay the full amount of their health care without discounts until they meet the minimum deductible for such a plan ($1,400 for an individual, $2,800 for a family).[50] In order to accommodate the IRS' concern, HHS opted to remove the restriction on use of copay accumulator adjustment policies altogether, rather than modify it to ensure that copay assistance is counted toward any deductible after the first $1,400 is met for enrollees who contribute to an HSA.

The failure of HHS to regulate insurers' use of copay accumulator adjustment policies prompted introduction of bipartisan legislation in the House of Representatives in November, 2021 entitled the "Help Ensure Lower Patient Copays Act (HELP Copays Act)," HR 5801.[51] The bill would address the issue by clarifying that prescription drug copays count as cost-sharing, and fall under the Affordable Care Act's existing provision that copayments made "by or on behalf" of an enrollee for covered services must be counted toward their annual deductible and out-of-pocket limit. It would also prohibit employer health plans from declaring some prescription drugs covered, but not part of their essential health benefits. The HELP Copays Act is poised to be reintroduced in the 118th Congress and will likely have a new bill number.

States Actions to Protect Patient Access to Prescriptions

While the federal government has not prohibited copay accumulator adjustment policies, HHS' 2021 Notice of Benefit and Payment Parameters allowed states to do so. The growing number of copay accumulator programs, combined with the lack of federal patient protections, has motivated more states to act. To date, **16 states and Puerto Rico** have adopted laws requiring insurance plans and pharmacy benefit managers (PBMs) to count the value of copay assistance toward an enrollee's annual deductible and out-of-pocket limit.

- To date, **eight 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: Connecticut, Delaware, Illinois, Louisiana, New York, Oklahoma, Virginia, West Virginia and Puerto Rico.
- **Eight more states** 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: Arizona, Arkansas, Georgia, Kentucky, Maine, North Carolina, Tennessee, and Washington.

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 of regulating those plans. 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. 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. The 16 states 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 2023 legislative sessions.

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. The federal government and state governments should take action to address this problem and help patients.

Endnotes

1 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.

2 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%-33% of plans with copay accumulators; Grade C have 34%-66% of plans with copay accumulators; Grade D have 67%-90% of plans with copay accumulators; Grade F have 100% of plans with copay accumulators.

3 States that have enacted legislation were excluded from the review: Arizona, Arkansas, Connecticut, Delaware, Georgia, Illinois, Kentucky, Louisiana, Maine, New York, North Carolina, Oklahoma, Tennessee, Virginia, Washington, West Virginia, and Puerto Rico.

4 Alabama, Alaska, California, Colorado, Florida, Idaho, Indiana, Iowa, Kansas, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Mexico, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Texas, Utah, Vermont, Wisconsin, Wyoming.

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

6 Rocky Mountain Health Plan, Colorado; Capital Health Plan, Coventry (Aenta CVS), Florida; St. Luke's Health Plan, Idaho; US Health & Life, Indiana; US Health & Life, Kansas; Priority Health, US Health & Life, Michigan; UPMC Health, Pennsylvania; Select Health, South Carolina; Avera, South Dakota; Ascension Personalized Care, Texas; MVP Health Care, Vermont.

7 A copay maximizer or variable copay program reduces an enrollee's monthly copayment to the equivalent of one-twelfth of the total manufacturer assistance available. Just like with a copay accumulator adjustment policy, the copay assistance is not applied to the deductible or out-of-pocket limit.

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Federal Regulation & Legislation Timeline

Timeline	Summary	Policy Vehicle
April 2019	The 2020 Notice of Benefit & Payment Parameters (NBPP) finalized in April 2019, included a provision that stated health plans must count manufacturer copay assistance toward the beneficiary's deductible and out-of-pocket costs for a brand drug where no generic equivalent is available. The provision also outlined the requirement to count manufacturer assistance for generic prescriptions through an appeals process.	2020 NBPP
August 2019	In August 2019, HHS with the Dept of Labor and Treasury Dept issued and FAQ about the ACA Implementation. This announced CCIIO's decision to delay enforcement of the copay accumulator provision of the 2020 NBPP, citing a possible conflict with a 2004 IRS rule related to high deductible health plans.	Tri-Agency FAQ
May 2020	The 2021 NBPP finalized in May 2020 reversed HHS' official policy on copay accumulators, leaving it to the discretion of health plans whether or not to count manufacturer copay assistance toward a beneficiary's cost-sharing responsibilities.	2021 NBPP
July 2020	Legislation was introduced in July 2020 in the House that would delay the implementation of the 2021 NBPP due to COVID-19.	HR 7647
November 2021	Legislation introduced in November 2021 by Representatives McEachin and R. Davis that will require copay assistance to be counted toward out- of-pocket cost-sharing requirements, and close a loophole that permits insurers to deem certain drugs "non-essential," for which no cost sharing paid will count toward the deductible or out-of-pocket maximum.	HR 5801

State Legislation

State	Copay Accumulator Language	Source / Date Signed into Law
West Virginia	When calculating an insured's contribution to any applicable cost sharing requirement, including, but not limited to, the annual limitation on cost sharing subject to 42 U.S.C. §18022(c) and 42 U.S.C. § 300gg-6(b): (1) An insurer shall include any cost sharing amounts paid by the insured or on behalf of the insured by another person; and (2) A pharmacy benefits manger shall include any cost sharing amounts paid by the insured or on behalf of the insured by another person.	West Virginia HB2770 3/9/2019
Virginia	When calculating an enrollee's overall contribution to any out-of-pocket maximum, deductible, copayment, coinsurance, or other cost-sharing requirement under a health plan, a carrier shall include any amounts paid by the enrollee or paid on behalf of the enrollee by another person.	Virginia SB1596 3/21/2019
Arizona	This law requires that financial assistance from outside parties, including drug manufacturers, count towards an enrollee's total out-of-pocket maximum when there is no generic version of their prescription medication available, or when the patient has received permission to take the name brand drug through prior authorization, step therapy, or an issuer's appeals process.	Arizona HB2166 4/11/2019
Illinois	A health care plan shall apply any third-party payments, financial assistance, discount, product vouchers, or any other reduction in out-of-pocket expenses made by or on behalf of such insured for prescription drugs toward a covered individual's deductible, copay, or cost-sharing responsibility, or out-of-pocket maximum associated with the individual's health insurance.	Illinois HB0465 8/23/2019
Georgia	When calculating an insured's contribution to any out-of-pocket maximum, deductible, or copayment responsibility, a pharmacy benefits manager shall include any amount paid by the insured or paid on his or her behalf through a third-party payment, financial assistance, discount, or product voucher for a prescription drug that does not have a generic equivalent or that has a generic equivalent but was obtained through prior authorization, a step therapy protocol, or the insurer's exceptions and appeals process.	Georgia SB313 8/5/2020

State	Copay Accumulator Language	Source / Date Signed into Law
Kentucky	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.	Kentucky SB45 3/25/21
Oklahoma	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.	Oklahoma HB2678 4/19/21
Arkansas	(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.	Arkansas HB1569 4/27/21

State	Copay Accumulator Language	Source / Date Signed into Law
Tennessee	(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).	Tennessee HB619 5/12/21
Connecticut	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.	Connecticut SB1003 6/2/21
Louisiana	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.	Louisiana SB94 6/21/21
North Carolina	(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.	North Carolina SB257 9/20/21

State	Copay Accumulator Language	Source / Date Signed into Law
Washington	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.	Washington SB5610 5/7/22
Maine	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.	Maine LD1783 5/7/22

State	Copay Accumulator Language	Source / Date Signed into Law
Delaware	(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.	Delaware SB267 10/26/22
New York	Section 1 requires any individual insurance policy that provides cover- age 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 York A1741 12/23/22

State	Copay Accumulator Language	Source / Date Signed into Law
Puerto Rico	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.	Puerto Rico S.1658
NCOIL Model Language	When calculating an enrollee's overall contribution to any out-of-pocket maximum or any cost-sharing requirement under a health plan, a [Carrier/ Insurer/Issuer] or pharmacy benefit manager shall include any amounts paid by the enrollee or paid on behalf of the enrollee by another person.	

2023 Copay Accumulator Data Collection Appendix

State	Issuer	CAAP	Grade
Alabama	Ambetter/Celtic	No	D
	BCBS	Yes	
	United HealthCare	Yes	
Alaska	Premera (BCBS)	Yes	F
	Moda	Yes	
Arizona	State Law		
Arkansas	State Law		
California	Aetna/CVS	Yes	C
	Anthem	Yes	
	Balance by CCHP	No	
	BlueShield California	Yes	
	Health Net	Yes	
	Kaiser Permanente	No	
	LA Care Health Plan	No	
	Molina	Yes	
	Oscar	Yes	
	Sharp Health	No	
	Valley Health Plan	No	
	Western Health Advantage	No	

* Plan applies copay assistance for brand drug with no generic equivalent to patient's deductible and out-of-pocket cost.

\+ Plan utilizes a copay maximizer or variable copay program.

State	Issuer	CAAP	Grade
Colorado	Anthem/BCBS	Yes	C
	Cigna	Yes	
	Denver Health Medical Plan/Elevate	No	
	Friday Health	No	
	Kaiser	No	
	Rocky Mountain	Yes	
Connecticut	State Law		
D.C.	Kaiser MidAtlantic	No*	A
	CareFirst Blue Choice HMO	No*	
	CareFirst PPO	No*	
Delaware	State Law		
Florida	Ambetter (Celtic) Sushine Health	No*	D
	Capital Health Plan	Yes	
	AvMed	Yes	
	Cigna	Yes	
	Coventry (AetnaCVS)	Yes	
	Florida Blue HMO (Health Options)	Yes	
	Florida Health Care Plan	Yes	
	Health First	Yes	
	Florida Blue (BCBS)	Yes	
	Molina	No*	
	Oscar	No*	
	UnitedHealthCare	Yes	

* Plan applies copay assistance for brand drug with no generic equivalent to patient's deductible and out-of-pocket cost.

\+ Plan utilizes a copay maximizer or variable copay program.

State	Issuer	CAAP	Grade
Georgia	State Law		
Hawaii	HMSA	No	A
	Kaiser	No	
Idaho	Blue Cross of Idaho	Yes	F
	Moda	Yes	
	Molina	No*	
	Mountain Health CO-OP	Yes+	
	PacificSource	Yes	
	Regence BS	Yes	
	SelectHealth	Yes	
	St. Luke's Health Plan	Yes	
Illinois	State Law		
Indiana	Celtics Insurane Co. (Ambetter)	No*	F
	Anthem	Yes	
	CareSource	Yes	
	Cigna	Yes	
	US Health & Life (Ascension)	Yes	
Iowa	Medica	Yes	F
	Oscar	Yes	
	Wellmark Health Plan	Yes	

* Plan applies copay assistance for brand drug with no generic equivalent to patient's deductible and out-of-pocket cost.

\+ Plan utilizes a copay maximizer or variable copay program.

State	Issuer	CAAP	Grade
Kansas	Medica	Yes	D
	BCBS of Kansas	No	
	BCBS of Kansas City	Yes	
	Sunflower State Healt Plan/Ambetter from Sunflower Health (Centene)	No	
	Oscar	No	
	Cigna	Yes	
	United Healthcare	Yes	
	US Health & Life (Ascension)	Yes	
Kentucky	State Law		
Louisiana	State Law		
Maine	State Law		
Maryland	CareFirst Blue Choice	No	B
	CareFirst BCBS	No	
	Kaiser	No	
	UnitedHealthcare	Yes	
Massachusetts	AllWays Health Partners(Mass General Brigham)	No	B
	BCBS	No	
	Fallon Community Health Plan	No	
	Harvard Pilgrim Health Care	No	
	Health New England	Yes	
	Tufts Health Plans	No	
	WellSense	No	
	United Healthcare	Yes	

* Plan applies copay assistance for brand drug with no generic equivalent to patient's deductible and out-of-pocket cost.

\+ Plan utilizes a copay maximizer or variable copay program.

State	Issuer	CAAP	Grade
Michigan	Blue Care Network	Yes	F
	BCBS	Yes	
	McLaren Health	Yes	
	Meridian (Ambetter)	No*	
	Molina	No*	
	Oscar Health	Yes	
	Physicians Health Plan	Yes	
	Total Health Care/Priority Health	Yes	
	US Health & Life (Ascension)	Yes	
	United HealthCare	Yes	
Minnesota	Blue Plus	Yes	F
	Medica	Yes	
	Group Health/Health Partners	Yes	
	UCare	Yes	
	Quartz	Yes	
Mississippi	Ambetter/Magnolia	No	C
	Molina	No*	
	Cigna	Yes	

* Plan applies copay assistance for brand drug with no generic equivalent to patient's deductible and out-of-pocket cost.

\+ Plan utilizes a copay maximizer or variable copay program.

State	Issuer	CAAP	Grade
Missouri	Aetna	No	F
	Anthem BCBS	Yes	
	Ambetter/Celtic (Centene)	Yes	
	BCBS Kansas City	Yes	
	Cigna	Yes+	
	Cox	Yes	
	Medica	Yes	
	Oscar	Yes	
	United Healthcare	Yes	
	SSM/WellFirst	No	
Montana	BCBS of Montana	Yes	F
	Montana Health CO-OP	Yes+	
	PacificSource	Yes	
Nebraska	Ambetter from NE Total Care	No	D
	BCBS of Nebraska	Yes+	
	Medica	Yes	
	Oscar	Yes	
Nevada	Aetna Health (of Utah Inc.)	Yes	D
	Anthem BCBS	Yes	
	Friday	No	
	Health Plan of NV	Yes	
	Hometown Health	Yes	
	Ambetter from SilverSummit	No	
	SelectHealth	Yes	

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\+ Plan utilizes a copay maximizer or variable copay program.

State	Issuer	CAAP	Grade
New Hampshire	Ambetter/Celtic	Yes	D
	Anthem	Yes	
	Harvard Pilgrim	No	
New Jersey	Aetna	No	A
	AmeriHealth	No	
	Horizon Healthcare Services (BCBS)	No	
	Oscar	No	
	WellCare (ambetter)	No	
New Mexico	BCBS	Yes	D
	Molina	Yes	
	Presbyterian Health Plan	Yes	
	Western Sky Community Care (Ambetter/Centene)	No	
New York	State Law		
North Carolina	State Law		
North Dakota	BCBS of North Dakota	No	C
	Medica	Yes	
	Sanford	No	

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State	Issuer	CAAP	Grade
Ohio	Aultcare	Yes	D
	Ambetter	No	
	(Anthem) BCBS	Yes	
	CareSource	Yes	
	Medical Mutual	Yes	
	Molina	Yes+	
	Oscar Buckeye State Insurance Corp	Yes	
	Oscar Insurance Corp. of Ohio	Yes	
	Paramount	Yes	
	United Healthcare	Yes	
	Summa	No	
Oklahoma	State Law		
Oregon	BridgeSpan	Yes	D
	Kaiser	No	
	Moda	Yes	
	PacificSource	Yes	
	Providence	No	
	Regence	Yes	
Pennsylvania	Capital Advantage Assurance	Yes	D
	Geisinger Health Plan	No	
	Geisinger Quality Options	No	
	Highmark, Inc.	No	

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State	Issuer	CAAP	Grade
Pennsylvania (cont.)	Keystone Health Plan East (Independence Blue Cross HMO)	Yes	D
	QCC Insurance Company (Independence Blue Cross PPO)	Yes	
	UPMC Health Options	Yes	
	UPMC Health Coverage	Yes	
	PA Health and Wellness (Ambetter)	No	
	Oscar Health	Yes	
	Cigna	Yes+	
Rhode Island	BCBS	Yes	C
	Neighborhood Health Plan of RI	No	
South Carolina	Ambetter/Absolute Total Care	Yes	F
	BC BS of South Carolina	Yes	
	Cigna	Yes	
	Molina	No*	
	(First Choice by) Select Health of South Carolina	Yes	
South Dakota	Avera	Yes	D
	Sanford	No	
	Wellmark of South Dakota	Yes	
Tennessee	State Law		

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State	Issuer	CAAP	Grade
Texas	Aetna/CVS	Yes	D
	Ascension Personalized Care	Yes	
	BCBS of Texas	Yes	
	Celtic/Ambetter	No	
	CHRISTUS	Yes	
	Cigna	Yes	
	Community Health Choice	Yes	
	Imperial Insurance Companies	Yes	
	Moda	Yes	
	Molina	Yes	
	Oscar	Yes	
	Sendero	No	
	FirstCare (acquired by Scott & White)	No	
	Scott & White Health Plan	No	
	United Healthcare of Texas	Yes	
Utah	BridgeSpan	Yes	D
	Cigna	No	
	Molina	No*	
	Regence	Yes	
	SelectHealth	Yes	
	University of Utah Health Plans	Yes+	
Vermont	BCBS of VT	No	C
	MVP Health Care	Yes	

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State	Issuer	CAAP	Grade
Virginia	State Law		
Washington	State Law		
West Virginia	State Law		
Wisconsin	Aspirus Health Plan	Yes	D
	Chorus Community Health Plan	Yes	
	Common Ground Healthcare Cooperative	Yes	
	Anthem BCBS	Yes	
	Dean Health Plan	No	
	Group Health Cooperative of South Central WI	No*	
	HealthPartners Insurance	Yes	
	Medica Health Plans of WI	Yes	
	MercyCare HMO	No	
	Molina	No*	
	Network Health	No	
	Quartz Health Benefits	Yes	
	Security Health Plan of Wisconsin	Yes	
Wyoming	BCBS of Wyoming	No	F
	Mountain Health CO-OP	Yes+	

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