

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 205  
(I-19)

Introduced by: Virginia, American Association of Clinical Urologists, West Virginia,  
New Jersey, Maryland, Alabama, Georgia, District of Columbia, Kentucky,  
Oklahoma, American Urological Society, Mississippi, Delaware, Illinois

Subject: Co-Pay Accumulators

Referred to: Reference Committee B  
(, Chair)

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1 Whereas, Virginia is the first state in the nation to pass legislation regulating Co-Pay  
2 Accumulators. Under a Co-Pay Accumulator program the value of a manufacturer's copay  
3 coupon is unable to be counted towards the beneficiary's deductible or out of pocket maximum.  
4 Once the coupon's value is exhausted, the beneficiary is still responsible for the deductible  
5 before plan benefits commence; and  
6

7 Whereas, Virginia Law, effective January 1, 2020, states "When calculating an enrollee's overall  
8 contribution to any out of pocket maximum, deductible, copayment, coinsurance, or other cost-  
9 sharing requirement under a health plan, a carrier shall include any amounts paid by the  
10 enrollee or paid on behalf of the enrollee by another person"; and  
11

12 Whereas, Two other states, including West Virginia and Arizona, have passed similar legislation  
13 in Spring of 2019 prohibiting health insurance plans from enacting co-pay accumulator policies  
14 that do not count third-party financial assistance toward a patient's out-of-pocket expenses; and  
15

16 Whereas, Several other states, including Illinois, Connecticut, Indiana, Kentucky, and North  
17 Carolina are considering passing their own laws to ban copay accumulator programs; therefore  
18 be it  
19

20 RESOLVED, That our American Medical Association develop model state legislation based on  
21 the recent law enacted in Virginia regarding Co-Pay Accumulators. (Directive to Take Action)

Fiscal Note: not yet determined.

Received: 08/29/19

# VIRGINIA ACTS OF ASSEMBLY -- 2019 SESSION

## CHAPTER 661

*An Act to amend and reenact §§ 38.2-4214 and 38.2-4319 of the Code of Virginia and to amend the Code of Virginia by adding in Article 1 of Chapter 34 of Title 38.2 a section numbered 38.2-3407.20, relating to health plans; calculation of enrollee's contribution to out-of-pocket maximum or cost-sharing requirement.*

[H 2515]

Approved March 21, 2019

**Be it enacted by the General Assembly of Virginia:**

**1. That §§ 38.2-4214 and 38.2-4319 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding in Article 1 of Chapter 34 of Title 38.2 a section numbered 38.2-3407.20 as follows:**

**§ 38.2-3407.20. Calculation of enrollee's contribution to out-of-pocket maximum or cost-sharing requirement.**

*A. As used in this section:*

*"Carrier" shall have the meaning set forth in § 38.2-3407.10; however, "carrier" also includes any person required to be licensed under this title that offers or operates a managed care health insurance plan subject to Chapter 58 (§ 38.2-5800 et seq.) or that provides or arranges for the provision of health care services, health plans, networks, or provider panels that are subject to regulation as the business of insurance under this title.*

*"Cost sharing" means any coinsurance, copayment, or deductible.*

*"Enrollee" means any person entitled to health care services from a carrier.*

*"Health care services" means items or services furnished to any individual for the purpose of preventing, alleviating, curing, or healing human illness, injury, or physical disability.*

*"Health plan" means any individual or group health care plan, subscription contract, evidence of coverage, certificate, health services plan, medical or hospital services plan, accident and sickness insurance policy or certificate, managed care health insurance plan, or other similar certificate, policy, contract, or arrangement, and any endorsement or rider thereto, to cover all or a portion of the cost of persons receiving covered health care services, that is subject to state regulation and that is required to be offered, arranged, or issued in the Commonwealth by a carrier licensed under this title. "Health plan" does not mean (i) coverages issued pursuant to Title XVIII of the Social Security Act, 42 U.S.C. § 1395 et seq. (Medicare), Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq. (Medicaid) or Title XXI of the Social Security Act, 42 U.S.C. § 1397aa et seq. (CHIP), 5 U.S.C. § 8901 et seq. (federal employees), or 10 U.S.C. § 1071 et seq. (TRICARE); or (ii) accident only, credit or disability insurance, long-term care insurance, TRICARE supplement, Medicare supplement, or workers' compensation coverages.*

*B. To the extent permitted by federal law and regulation, when calculating an enrollee's overall contribution to any out-of-pocket maximum or any 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.*

*C. This section shall apply with respect to health plans that are entered into, amended, extended, or renewed on or after January 1, 2020.*

*D. Pursuant to the authority granted by § 38.2-223, the Commission may promulgate such rules and regulations as it may deem necessary to implement this section.*

**§ 38.2-4214. Application of certain provisions of law.**

No provision of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-200, 38.2-203, 38.2-209 through 38.2-213, 38.2-218 through 38.2-225, 38.2-230, 38.2-232, 38.2-305, 38.2-316, 38.2-316.1, 38.2-322, 38.2-325, 38.2-326, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, 38.2-700 through 38.2-705, 38.2-900 through 38.2-904, 38.2-1017, 38.2-1018, 38.2-1038, 38.2-1040 through 38.2-1044, Articles 1 (§ 38.2-1300 et seq.) and 2 (§ 38.2-1306.2 et seq.) of Chapter 13, §§ 38.2-1312, 38.2-1314, 38.2-1315.1, 38.2-1317 through 38.2-1328, 38.2-1334, 38.2-1340, 38.2-1400 through 38.2-1442, 38.2-1446, 38.2-1447, 38.2-1800 through 38.2-1836, 38.2-3400, 38.2-3401, 38.2-3404, 38.2-3405, 38.2-3405.1, 38.2-3406.1, 38.2-3406.2, 38.2-3407.1 through 38.2-3407.6:1, 38.2-3407.9 through 38.2-3407.19, 38.2-3407.20, 38.2-3409, 38.2-3411 through 38.2-3419.1, 38.2-3430.1 through 38.2-3454, 38.2-3501, 38.2-3502, subdivision 13 of § 38.2-3503, subdivision 8 of § 38.2-3504, §§ 38.2-3514.1, 38.2-3514.2, §§ 38.2-3516 through 38.2-3520 as they apply to Medicare supplement policies, §§ 38.2-3522.1 through 38.2-3523.4, 38.2-3525, 38.2-3540.1, 38.2-3541 through 38.2-3542, 38.2-3543.2, Article 5 (§ 38.2-3551 et seq.) of Chapter 35, Chapter 35.1 (§ 38.2-3556 et seq.), §§ 38.2-3600 through 38.2-3607, Chapter 52

(§ 38.2-5200 et seq.), Chapter 55 (§ 38.2-5500 et seq.), and Chapter 58 (§ 38.2-5800 et seq.) of this title shall apply to the operation of a plan.

**§ 38.2-4319. Statutory construction and relationship to other laws.**

A. No provisions of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-100, 38.2-136, 38.2-200, 38.2-203, 38.2-209 through 38.2-213, 38.2-216, 38.2-218 through 38.2-225, 38.2-229, 38.2-232, 38.2-305, 38.2-316, 38.2-316.1, 38.2-322, 38.2-325, 38.2-326, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, Chapter 9 (§ 38.2-900 et seq.), §§ 38.2-1016.1 through 38.2-1023, 38.2-1057, 38.2-1306.1, Article 2 (§ 38.2-1306.2 et seq.), § 38.2-1315.1, Articles 3.1 (§ 38.2-1316.1 et seq.), 4 (§ 38.2-1317 et seq.), 5 (§ 38.2-1322 et seq.), 5.1 (§ 38.2-1334.3 et seq.), and 5.2 (§ 38.2-1334.11 et seq.) of Chapter 13, Articles 1 (§ 38.2-1400 et seq.), 2 (§ 38.2-1412 et seq.), and 4 (§ 38.2-1446 et seq.) of Chapter 14, Chapter 15 (§ 38.2-1500 et seq.), Chapter 17 (§ 38.2-1700 et seq.), §§ 38.2-1800 through 38.2-1836, 38.2-3401, 38.2-3405, 38.2-3405.1, 38.2-3406.1, 38.2-3407.2 through 38.2-3407.6:1, 38.2-3407.9 through 38.2-3407.19, 38.2-3407.20, 38.2-3411, 38.2-3411.2, 38.2-3411.3, 38.2-3411.4, 38.2-3412.1, 38.2-3414.1, 38.2-3418.1 through 38.2-3418.17, 38.2-3419.1, 38.2-3430.1 through 38.2-3454, 38.2-3500, subdivision 13 of § 38.2-3503, subdivision 8 of § 38.2-3504, §§ 38.2-3514.1, 38.2-3514.2, 38.2-3522.1 through 38.2-3523.4, 38.2-3525, 38.2-3540.1, 38.2-3540.2, 38.2-3541.2, 38.2-3542, 38.2-3543.2, Article 5 (§ 38.2-3551 et seq.) of Chapter 35, Chapter 35.1 (§ 38.2-3556 et seq.), Chapter 52 (§ 38.2-5200 et seq.), Chapter 55 (§ 38.2-5500 et seq.), and Chapter 58 (§ 38.2-5800 et seq.) shall be applicable to any health maintenance organization granted a license under this chapter. This chapter shall not apply to an insurer or health services plan licensed and regulated in conformance with the insurance laws or Chapter 42 (§ 38.2-4200 et seq.) except with respect to the activities of its health maintenance organization.

B. For plans administered by the Department of Medical Assistance Services that provide benefits pursuant to Title XIX or Title XXI of the Social Security Act, as amended, no provisions of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-100, 38.2-136, 38.2-200, 38.2-203, 38.2-209 through 38.2-213, 38.2-216, 38.2-218 through 38.2-225, 38.2-229, 38.2-232, 38.2-322, 38.2-325, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, Chapter 9 (§ 38.2-900 et seq.), §§ 38.2-1016.1 through 38.2-1023, 38.2-1057, 38.2-1306.1, Article 2 (§ 38.2-1306.2 et seq.), § 38.2-1315.1, Articles 3.1 (§ 38.2-1316.1 et seq.), 4 (§ 38.2-1317 et seq.), 5 (§ 38.2-1322 et seq.), 5.1 (§ 38.2-1334.3 et seq.), and 5.2 (§ 38.2-1334.11 et seq.) of Chapter 13, Articles 1 (§ 38.2-1400 et seq.), 2 (§ 38.2-1412 et seq.), and 4 (§ 38.2-1446 et seq.) of Chapter 14, §§ 38.2-3401, 38.2-3405, 38.2-3407.2 through 38.2-3407.5, 38.2-3407.6, 38.2-3407.6:1, 38.2-3407.9, 38.2-3407.9:01, and 38.2-3407.9:02, subdivisions F 1, F 2, and F 3 of § 38.2-3407.10, §§ 38.2-3407.11, 38.2-3407.11:3, 38.2-3407.13, 38.2-3407.13:1, 38.2-3407.14, 38.2-3411.2, 38.2-3418.1, 38.2-3418.2, 38.2-3419.1, 38.2-3430.1 through 38.2-3437, 38.2-3500, subdivision 13 of § 38.2-3503, subdivision 8 of § 38.2-3504, §§ 38.2-3514.1, 38.2-3514.2, 38.2-3522.1 through 38.2-3523.4, 38.2-3525, 38.2-3540.1, 38.2-3540.2, 38.2-3541.2, 38.2-3542, 38.2-3543.2, Chapter 52 (§ 38.2-5200 et seq.), Chapter 55 (§ 38.2-5500 et seq.), and Chapter 58 (§ 38.2-5800 et seq.) shall be applicable to any health maintenance organization granted a license under this chapter. This chapter shall not apply to an insurer or health services plan licensed and regulated in conformance with the insurance laws or Chapter 42 (§ 38.2-4200 et seq.) except with respect to the activities of its health maintenance organization.

C. Solicitation of enrollees by a licensed health maintenance organization or by its representatives shall not be construed to violate any provisions of law relating to solicitation or advertising by health professionals.

D. A licensed health maintenance organization shall not be deemed to be engaged in the unlawful practice of medicine. All health care providers associated with a health maintenance organization shall be subject to all provisions of law.

E. Notwithstanding the definition of an eligible employee as set forth in § 38.2-3431, a health maintenance organization providing health care plans pursuant to § 38.2-3431 shall not be required to offer coverage to or accept applications from an employee who does not reside within the health maintenance organization's service area.

F. For purposes of applying this section, "insurer" when used in a section cited in subsections A and B shall be construed to mean and include "health maintenance organizations" unless the section cited clearly applies to health maintenance organizations without such construction.

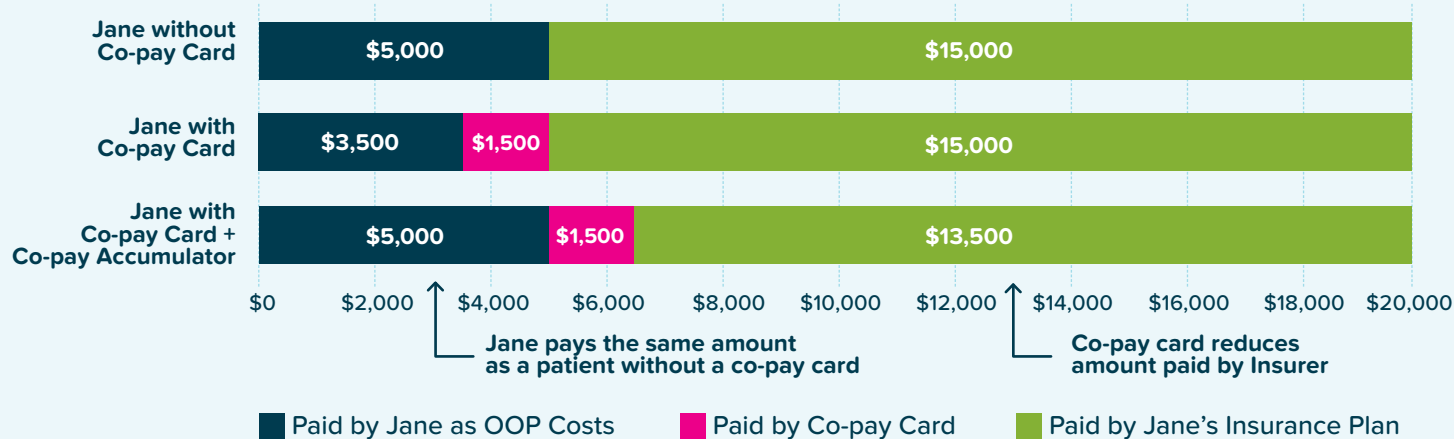
# Co-pay Accumulator Programs

## What is a Co-pay Accumulator Program?

- » A co-pay accumulator program—also known as an accumulator adjustment program—is a new kind of policy being adopted by some insurance plans.
- » These programs change the way a patient's out-of-pocket (OOP) medication costs are added up (accumulated) and applied toward meeting the OOP maximum under their insurance policy.
- » OOP drug costs are the part of a patient's medication expenses not covered by insurance.
- » **Deductibles, co-payments and coinsurance** are three types of OOP drug costs:
  - A **deductible** is the amount that a patient must pay before their insurance plan begins covering the cost of their medications.
  - A **co-payment** is a flat fee (ex: \$10) that patients pay each time they fill a prescription.
  - **Coinsurance** is a percentage of the cost of each prescription that is filled.
  - Depending on the cost of the drug, some insurance plans have levels or "tiers" of co-payments/coinsurance, with higher OOP costs for more expensive drugs.

## What Are Co-pay Cards and How Have They Been Used in the Past?

- » Some drug manufacturers offer co-pay cards to help underinsured patients afford their prescription medications.
  - Only patients with commercial insurance can use these cards.
- » Many patients use co-pay cards to help pay their deductibles, co-pays or coinsurance, and reduce their OOP drug costs.
- » The illustration below shows the impact of a \$1,500 co-pay card on the OOP drug costs for a hypothetical patient, Jane, with multiple sclerosis, who has:
  - \$20,000 in drug costs for the year.
  - An insurance policy with maximum OOP costs of \$5,000 (deductible + co-pays + coinsurance).
- » Without a co-pay card, Jane would need to pay \$5,000 in OOP costs to access her medications, with insurance covering the remaining \$15,000.
- » With a co-pay card, she would need to pay only \$3,500 in OOP costs for the year.



## What Happens to Patients Under Co-pay Accumulator Programs?

- » Co-pay accumulator programs prevent patients from using co-pay cards to cover their OOP drug costs.
- » In the example above, Jane no longer benefits from her \$1,500 co-pay card.
  - She must pay the full \$5,000 in OOP costs to access her medications.
  - These are the same OOP costs that would be paid by Jane without a co-pay card.
- » For some patients, the extra OOP drug costs that are incurred under co-pay accumulator programs will make their prescription medications unaffordable. Many of these patients will:
  - Stop their treatment.
  - Reduce their dose, skip doses or cut pills to make their medication last longer.
  - Be forced to choose between staying on their medication and covering other costs such as food, housing and utilities.

## Who is Affected by Co-pay Accumulator Programs?

- » Patients with commercial insurance—especially those who get insurance through their employers or through the Affordable Care Act.
- » Co-pay accumulator programs are especially challenging for patients who:
  - Require expensive medications.
  - Have health insurance plans with high deductibles or high co-payments/coinsurance.
  - Are economically vulnerable.
- » *Many patients do not know that their health plans have co-pay accumulator programs until they get to the pharmacy counter and are confronted with unexpected OOP drug expenses.*

## Steps You Can Take

- » Find out if your health insurance plan has a co-pay accumulator program.
- » Be sure you know your plan's annual deductible and the co-payments/coinsurance for the medications you take so that you understand what your OOP drug costs will be for your prescription medications.
- » Talk to your benefits manager or health plan about how the co-pay accumulator program impacts your ability to remain on your treatment.
- » Inform your healthcare provider that your insurance plan has a co-pay accumulator program, and how the program impacts your ability to cover the OOP costs for your medications.
- » Share your story with a patient advocacy group.

## The PAN Foundation

The mission of the PAN Foundation is to help underinsured people with life-threatening, chronic and rare diseases get the medications and treatment they need by paying for their out-of-pocket costs and advocating for improved access and affordability.

For more information about the PAN Foundation, visit [www.panfoundation.org](http://www.panfoundation.org).