THE AIDS INSTITUTE

Shortchanged:

The Patient Impact of Copay Accumulator Policies in 2026

THEAIDSINSTITUTE.ORG

Introduction

The rising cost of health care remains a top concern for Americans as more families struggle to afford insurance and the care they need. People living with rare, serious, and complex chronic illnesses are shouldering more financial burden as out-of-pocket costs continue to increase. Specialty treatment and medications to manage chronic conditions, such as HIV, viral hepatitis, cancer or multiple sclerosis, can be costly. 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 patients 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 "copay accumulator adjustment policies" (CAAPs), used by health insurance companies and the pharmacy benefit managers (PBMs) they employ to administer their prescription drug benefits. "CAAP" is a short way of saying that health insurance plans pocket the copayments they receive without crediting the payments to the enrollee's annual deductible or out-of-pocket limit, when the payment uses manufacturer copay assistance. 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.
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. HHS has to date refused to enforce the rule despite the court's decision.

State governments have been more clear: To date, 26 states, the District of Columbia, and Puerto Rico have enacted laws restricting the use of CAAPs.

State governments have been more clear: To date, 26 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. 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 2026.

The AIDS Institute reviewed individual health insurance plans available for 2026 on the health insurance marketplaces in all 50 states and DC. Our analysis shows that nationwide, nearly 40% of plans include a CAAP, and that in 31 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.

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 and reintroduced in 2025. The "Help Ensure Lower Patient (HELP) Copays Act," garnered significant bipartisan support in both the Senate and the House. 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 insurers and PBMs count all copays they receive on behalf of their enrollees toward the enrollee's annual out-of-pocket expenses – not just some of them.

Methodo

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 DC. 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 the copay assistance policies were ambiguous or the documents were unavailable, we called customer service lines to speak with insurance plan representatives.

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 2026 found that copay accumulator adjustment policies are widespread:

1. Nationwide, **nearly 40%** of all individual marketplace plans we reviewed have copay accumulator adjustment policies, but there is wide variation state to state.
    - In **19** states and Washington DC, **zero** plans include CAAPs, ensuring that all patients receive the full benefit of patient copay assistance, regardless of the plan in which the patient is enrolled. These states scored a **Grade A** for 2026.
        - In **17** states plus DC, state laws restrict CAAPs in 2026: AR, AZ, CO, CT, DC, GA, IL, KY, ME, NJ, NM, NY, OK, OR, TX, VA, VT, WV.
        - In **1** state, the department of insurance has enforced the federal

rule restricting the use of CAAPs through the plan rate filing and certification process: MN.
    - In **1** state, all plans voluntarily opted not to include CAAPs when not obligated by law or regulation: HI.
- In **31** states**,** there is **at least 1** plan with a copay accumulator adjustment policy.
    - In **4** states, up to **25%** of available plans have a copay accumulator adjustment policy. These states earned a **Grade B** for 2026: LA, MD, NC, WA.
    - In **12** states, between **25% and 50%** of plans include a CAAP. These states earned a **Grade C** for 2026: AL, AK, CA, DE, IA, IN, MA, NV, ND, RI, SD, TN.
    - In **4** states**, 50% - 75%** of available plans include a CAAP. These states earned a **Grade D** for 2026: FL, KS, NE, NH.
    - In **11** states, 75% - 100% of available plans included a CAAP. These states earned a **Grade F** for 2026: ID, MI, MO, MS, MT, OH, PA, SC, UT, WI, WY.

2. Information about CAAPs is confusing and difficult to find. Comprehensive policy documents are not always made available online at all, can be difficult to search for on the plans' websites or can be hidden behind a member portal; the copay policies can be buried within hundreds of pages of plan documents; and the policies can be difficult to decipher and are 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, calling customer service can be time-consuming and arduous; callers are often transferred between different departments, wait-times can last up to hours, and unfortunately, representatives are not always knowledgeable about their company's policy and cannot answer confidently. In some cases, we were unable to reach a representative at all, suggesting that people shopping for coverage may have the same problem. Health insurance is one of the only products that a person must buy without knowing exactly what they are purchasing.
    - **20** plans in **18** states did not make plan and policy documents available online during the open enrollment period: CA, DE, FL, IA, ID, KS, LA, MA, MD, ME, MI, NC, NY OH, PA, SD, VA, VT.
    - **7** of those plans have a CAAP, according to customer service representatives.

3. 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 **9** of the **25** states and DC that have enacted laws restricting the use of CAAPs, at **least 1** plan continues to include CAAP language: DE, IN, IA, LA, MD, NC, ND, TN, WA.
    - In **1** state requiring 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: NV.[i]

Following the publication of our past reports, we reached out to state departments of insurance to bring to their attention that issuers may potentially be out of compliance with state laws and rules. We received feedback that after following up with issuers, the departments of insurance do not believe the issuers are implementing copay diversion policies. This presents a discrepancy between the issuers' written policies and practices.

4. Some plans institute 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. (Sometimes, this is referred to as a "copay maximizer program".) In **12** states, there is **at least 1** plan with a variable copay program: ID, MD, MS, MO, NE, NH, OH, PA, RI, UT, WI, WY. Since there are no rules governing them, so-called "variable copay programs" can operate in different ways:
   - Copay amounts are not available in plan materials. They may be set at an amount that divides the available 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.

...es

State	# of Insurers	# of Plans w/CAAPs	% of Plans w/CAAP	Grade
Arizona	7	0	0%	A
Arkansas	4	0	0%	A
Colorado	6	0	0%	A
Connecticut	3	0	0%	A
DC	2	0	0%	A
Georgia	8	0	0%	A
Hawaii	2	0	0%	A
Illinois	7	0	0%	A
Kentucky	3	0	0%	A
Maine	4	0	0%	A
Minnesota	6	0	0%	A
New Jersey	5	0	0%	A

Note: States listed in ***italics*** have a state law or rule restricting use of CAAPs in effect in 2026.

2026 State Grades

State	# of Insurers	# of Plans w/CAAPs	% of Plans w/CAAP	Grade
New Mexico	4	0	0%	A
New York	12	0	0%	A
Oklahoma	7	0	0%	A
Oregon	6	0	0%	A
Texas	15	0	0%	A
Vermont	2	0	0%	A
Virginia	8	0	0%	A
West Virginia	2	0	0%	A
Louisiana	6	1	17%	B
Maryland	5	1	20%	B
North Carolina	6	1	17%	B
Washington	10	1	10%	B
Alabama	4	2	50%	C
Alaska	2	1	50%	C
California	11	5	46%	C
Delaware	3	1	33%	C
Indiana	5	2	40%	C
Iowa	6	3	50%	C
Massachusetts	8	4	50%	C
Nevada	9	4	44%	C
North Dakota	3	1	33%	C
Rhode Island	2	1	50%	C
South Dakota	3	1	33%	C
Tennessee	6	2	33%	C
Florida	16	10	63%	D

Note: States listed in *italics* have a state law or rule restricting use of CAAPs in effect in 2026.

2026 State Grades

State	# of Insurers	# of Plans w/CAAPs	% of Plans w/CAAP	Grade
Kansas	6	4	67%	D
Nebraska	5	3	60%	D
New Hampshire	4	3	75%	D
Idaho	8	8	100%	F
Michigan	7	6	86%	F
Mississippi	5	4	80%	F
Missouri	7	6	86%	F
Montana	3	3	100%	F
Ohio	11	10	91%	F
Pennsylvania	13	10	77%	F
South Carolina	6	6	100%	F
Utah	6	5	83%	F
Wisconsin	12	11	92%	F
Wyoming	2	2	100%	F

Note: States listed in *italics* have a state law or rule restricting use of CAAPs in effect in 2026.

Discus

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"). 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. In 2026, the individual out-of-pocket limit on health care expenses is $10,600, and it is twice that amount for a family ($21,200). Almost half (45%) of all single-person, non-elderly households don't have enough savings to pay over $2,000 for cost-sharing and 63% could not pay over $6,000; 42% of multi-person, non-elderly households do not have more than $4,000 and 61% could not pay $12,000. $10,000 or more for an out-of-pocket limit (or double that

for a family) is simply unrealistic for the majority of Americans. Chart 1 in Appendix 2 shows the growth of annual deductibles and the max out-of-pocket limit for patients over time.

As premiums soar, out-of-pocket limits increase, and copayments balloon, patients are finding it harder and harder to afford the critical health care they need.

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. 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.

In 2026, patients enrolling in ACA marketplace plans will experience an additional, significant financial burden. More than 20 million people who are enrolled in marketplace coverage (93% of enrollees) receive premium tax credits (PTCs) that help lower the cost of their monthly premium. In 2021, Congress made the PTCs more generous to improve affordability and expand coverage to healthcare during the public health crisis. It was a successful policy, with enrollment in the ACA marketplaces more than doubling between 2021 and 2025. However, the provision that enhanced the PTCs was temporary and expired at the end of 2025. Congress failed to extend the provision and 24 million Americans saw their premiums for 2026 health insurance plans skyrocket. Insurers have raised premiums each year, and for 2026, insurers proposed an increase of approximately 26% for base premiums; this is on top of the expiring enhanced PTCs. On average, premiums in 2026 are more than double what enrollees paid in 2025. 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 and jeopardizing their health to avoid another medical bill. In a KFF poll of US families, more than one third of adults (36%) cited cost as a reason for skipping or postponing health care; 21% stated cost was the reason for not filling a prescription. As premiums soar, out-of-pocket limits increase, and copayments balloon, patients are finding it harder and harder to afford the critical health care they need.

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 specify 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 and there is no other alternative option.

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 never hit their out-of-pocket limit, even though the insurer has received $10,000 or more in payment.

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 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. Patients only turn to copay assistance to help cover their share of the cost for medications once the insurer and/or PBM has ***approved*** coverage for a specialty or high-cost brand medication.

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.

Federal Regulation

The current federal rule about copay accumulator adjustment policies was finalized in the 2020 Notice of Benefit and Payment Parameters (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. 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. 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.

While the federal government has not prohibited CAAPs, HHS' 2021 Notice of Benefit and Payment Parameters allowed states to do so.

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 2025 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 ACA'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 regard to cost-sharing. While this clarification only applies to the state-regulated marketplace plans, the Departments of Labor, Treasury, and HHS announced their intention to issue a complimentary rule that would apply to employer-sponsored plans, creating consistent policies on prescription drugs as essential health benefits across insurance markets. However, that rule has not yet been issued.

State Laws Restricting Copay Diversion Policies

While the federal government has not prohibited CAAPs, HHS' 2021 Notice of Benefit and Payment Parameters allowed states to do so. To date, 26 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, **11** states and **1** 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,

IA, LA, NJ, NM, NY, OK, VA, WV, PR.

- **15** 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, IN, KY, ME, MD, NC, ND, OR, TN, TX, WA, 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. We urge state regulators in the ten states and DC that have plans with CAAP language in their plan documents despite state laws or rules to work with their plans to ensure that their policies and documents are in alignment with their state laws.

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, and was reintroduced in 2025 in the 119th Congress. 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.

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 all insurance plans 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. This will ensure patients across the country can afford their critical prescription drugs.

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. Shameek Rakshit, Matthew McGough, Lynn Cotter, Gary Claxton; Peterson-KFF Health System Tracker, How does cost affect access to healthcare?, April 7, 2025, https://www.kff.org/affordable-care-act/kff-health-tracking-poll-february-2024-voters-on-two-key-health-care-issues-affordability-and-aca/.
2. Nora Becker, John Scott, Michelle Moniz, Erin Carlton, John Ayanian, "Association of chronic disease with patient financial outcomes among commercially insured adults," JAMA Internal Medicine vol. 182, 10, October 1, 2022, https://pmc.ncbi.nlm.nih.gov/articles/PMC9396471/#H1-4-IOI220051.
3. 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
4. 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."
5. 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.
6. 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.
7. 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.
8. 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.
9. 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.
10. The Governor of NJ signed legislation restricting CAAPs on January 9, 2026. That law goes into effect April 1, 2026. The legislation was passed on December 22, 2025.
11. 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.
12. 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.
13. NV Division of Insurance, 2026 Health Benefit Plan Filing Guidance, https://doi.nv.gov/uploadedFiles/doi.nv.gov/Content/Insurers/Life_and_Health/PY26_NVMED_%20Filing%20Guidance_FINAL_062425.pdf.

    MN Department of Commerce and Health, MN 2025 Annual Instructions Guide, April 22, 2024, https://acrobat.adobe.com/id/urn:aaid:sc:US:2602bf59-c0c7-4a30-99f7-1c3372523678.
14. 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/.

Endnotes

15. Gregory Young, Matthew Rae, Gary Claxton, Emma Wager, Krutika Amin, "How many people have enough money to afford private insurance cost sharing?" Peterson-KFF Health Systems Tracker, March 10, 2022, https://www.healthsystemtracker.org/brief/many-households-do-not-have-enough-money-to-pay-cost-sharing-in-typical-private-health-plans/#Share%20of%20households%20without%20enough%20liquid-%20assets%20to%20pay%20typical%20private%20plan%20cost-sharing%20amounts,%202019

16. 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.

17. Gideon Lukens, Elizabeth Zhang, Center on Budget and Policy Priorities, "Health Insurance Premium Spikes Imminent as Tax Credit Enhancements Set to Expire." November 3, 2025, https://www.cbpp.org/research/health/health-insurance-premium-spikes-imminent-as-tax-credit-enhancements-set-to-expire.

18. KFF, Enrollment Growth in the ACA Marketplaces, Jared Ortaliza, Justin Lo, Cynthia Cox, April 2, 2025, https://www.kff.org/affordable-care-act/enrollment-growth-in-the-aca-marketplaces/.

19. Justin Lo, Larry Levitt, Jared Ortaliza, Cynthia Cox, "ACA marketplace premium payments would more than double on average next year if enhanced premium tax credits expire," September 30, 2025, https://www.kff.org/affordable-care-act/aca-marketplace-premium-payments-would-more-than-double-on-average-next-year-if-enhanced-premium-tax-credits-expire/.

20. Sara Collins, Shreya Roy, Relebohile Masitha, Commonwealth Fund, "Paying for it: How health care costs and medical debt are making Americans sicker and poorer," October 26, 2023, https://www.commonwealthfund.org/publications/surveys/2023/oct/paying-for-it-costs-debt-americans-sicker-poorer-2023-affordability-survey#:~:text=Insurance%20coverage%20didn't%20prevent,and%2022%20percent%20in%20Medicare.

21. Grace Sparks, Lunna Lopes, Alex Montero, Marley Presiado, Liz Hamel, KFF, "Americans' Challenges with Health Care Costs," December 11, 2025, https://www.kff.org/health-costs/americans-challenges-with-health-care-costs/.

22. 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.

23. 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 enrollees 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).

24. US Federal Register, Patient Protection and Affordable Care Act; HHS Notice of Benefit & Payment Parameterse for 2020, April 25, 2019, https://www.federalregister.gov/d/2019-08017/p-895.

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

26. 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.

27. 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-and-publications/reports/the-global-use-of-medicine-in-2019-and-outlook-to-2023.

28. 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.

Appendix 1: Copay Assistance Diversion Policies in 2026 Marketplace Plans

State	Issuer	CAAP	Grade
Alabama	Ambetter/Celtic		C
	BC & BS of Alabama		
	Oscar	✓	
	UnitedHealthCare	✓	
Alaska	Premera (BCBS of Alaska)		C
	Moda Health Plan, Inc.	✓	
Arizona	Ambetter from Arizona Complete Health		A
	Antidote Health Plan		
	Blue Cross Blue Shield of Arizona	*	
	Cigna HealthCare of Arizona	*	
	Imperial Insurance Companies	*	
	Oscar Health Plan, Inc.		
	UnitedHealthcare		
Arkansas	Ambetter from Arkansas Health & Wellness	*	A
	Arkansas Blue Cross Blue Shield		
	Health Advantage		
	Octave		
California	Anthem Blue Cross of CA	✓	C
	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		

✓ 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.

Appendix 1: Copay Assistance Diversion Policies in 2026 Marketplace Plans

State	Issuer	CAAP	Grade
Colorado	Anthem	*	A
	Cigna Healthcare	*	
	Denver Health Plan	*	
	Kaiser Permanente	*	
	Rocky Mountain Health Plans	*	
	SelectHealth	*	
Connecticut	Anthem		A
	ConnectiCare Benefits		
	ConnectiCare Insurance Company Inc.		
Delaware	Ambetter Health of Delaware		C
	AmeriHealth Caritas Next	✓	
	Highmark Blue Cross Blue Shield Delaware		
District of Columbia	Kaiser		A
	CareFirst BlueCross BlueShield	*	
Florida	AmeriHealth Caritas Next	✓	D
	AvMed	✓	
	Florida Blue (BC BS)	✓	
	Capital Health Plan	✓	
	Ambetter (underwritten by Centene)		
	Cigna Health & Life		
	Cigna Healthcare		
	22Health (Community Care Network)	✓	
	Florida Health Care Plan	✓	
	Health First Commercial Plans	✓	
	Florida Blue HMO (Health Options)	✓	
	Molina Healthcare	*	
	Oscar HMO of Florida	✓	
	WellPoint (Simply Healthcare Plans)		
	Ambetter (underwritten by Sunshine State Health Plan)		
	UnitedHealthCare	✓	

Appendix 1: Copay Assistance Diversion Policies in 2026 Marketplace Plans

State	Issuer	CAAP	Grade
Georgia	Alliant Health Plans		A
	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	Hawaii Medical Service Association (HMSA)		A
	Kaiser Permanente		
Idaho	Blue Cross of Idaho	✓	F
	Moda	✓	
	Molina	✓	
	Mountain Health CO-OP	✓	
	PacificSource	✓	
	Regence BS	✓	
	SelectHealth	✓	
	St. Luke's Health Plan	✓	
Illinois	Ambetter of Illinois		A
	Blue Cross and Blue Shield of Illinois		
	Cigna Healthcare		
	MercyCare Health Plans		
	Molina Healthcare		
	Oscar Health Plan, Inc.		
	UnitedHealthcare		
Indiana	Ambetter Health from MHS	*	C
	Anthem Blue Cross and Blue Shield	✓	
	CareSource		
	Cigna		
	United Healthcare	✓	

Appendix 1: Copay Assistance Diversion Policies in 2026 Marketplace Plans

State	Issuer	CAAP	Grade
Iowa	Avera Health Plans		C
	Iowa Total Care (Ambetter)	*	
	Medica	✓	
	Oscar	✓	
	Wellmark		
	UnitedHealthcare	✓	
Kansas	Ambetter from Sunflower Health		D
	BCBS of Kansas	✓	
	BCBS of Kansas City	✓	
	Medica	✓	
	Oscar		
	United Healthcare	✓	
Kentucky	Anthem Health Plans of KY		A
	Passport by Molina Healthcare	*	
	Wellcare Health Plans of Kentucky, Inc. (Ambetter)	*	
Louisiana	Ambetter from Louisiana Healthcare Connections		B
	AmeriHealth Caritas Next		
	Blue Cross Blue Shield of Louisiana (LA Health Service and Indemnity Company)		
	HMO Louisiana Blue		
	CHRISTUS Health Plan		
	United Healthcare	✓	
Maine	Anthem		A
	Community Health Options		
	Harvard Pilgrim HealthCare		
	Mending Health (formerly Taro)	*	

Appendix 1: Copay Assistance Diversion Policies in 2026 Marketplace Plans

State	Issuer	CAAP	Grade
Maryland	CareFirst BlueCross BlueShield (PPO)		B
	CareFirst BlueChoice (HMO)		
	Kaiser Permanente	*	
	Wellpoint	✓	
	UnitedHealthcare		
Massachusetts	BCBS of Mass		C
	Fallon Community Health Plan		
	Harvard Pilgrim Health Care	✓	
	Health New England	✓	
	Mass General Brigham		
	Tufts Health Plans	✓	
	WellSense		
	United Healthcare	✓	
Michigan	Ambetter by Meridian		F
	Blue Care Network of MI	✓	
	Blue Cross Blue Shield	✓	
	McLaren Health	✓	
	Oscar Health	✓	
	Priority Health	✓	
	United Healthcare	✓	
Minnesota (Reg state)	BCBS Minnesota		A
	Health Partners, Inc.		
	Health Partners Insurance Company		
	Medica		
	Quartz		
	UCare		

Appendix 1: Copay Assistance Diversion Policies in 2026 Marketplace Plans

State	Issuer	CAAP	Grade
Mississippi	Ambetter from Magnolia		F
	Cigna Healthcare	✓	
	Molina	✓	
	Oscar	✓	
	UnitedHealthcare	✓	
	Anthem	✓	
Missouri	Ambetter from Home State Health		F
	BlueCross BlueShield of Kansas City	✓	
	Cox Health Systems Insurance Co.	✓	
	Medica	✓	
	Oscar	✓	
	United Healthcare	✓	
Montana	Blue Cross and Blue Shield of Montana	✓	F
	Montana Health CO-OP	✓	
	PacificSource Health Plans	✓	
Nebraska	Ambetter		D
	BCBS of Nebraska	✓	
	Medica	✓	
	Oscar	✓	
	United Healthcare		
Nevada	Ambetter from Silver Summit		C
	Anthem	✓	
	CareSource	*	
	Community Care Health Plan of Nevada	✓	
	Health Plan of Nevada, Inc.	✓	
	Hometown Health	*	
	Imperial	*	
	Molina		
	SelectHealth	✓	

Appendix 1: Copay Assistance Diversion Policies in 2026 Marketplace Plans

State	Issuer	CAAP	Grade
New Hampshire	Ambetter (NH Healthy Families)	✓	D
	Anthem Blue Cross and Blue Shield	✓	
	Harvard Pilgrim	✓	
	WellSense		
New Jersey	AmeriHealth Ins Company of NJ		A
	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	*	

Appendix 1: Copay Assistance Diversion Policies in 2026 Marketplace Plans

State	Issuer	CAAP	Grade
North Carolina	Ambetter of North Carolina		B
	AmeriHealth Caritas Next		
	Blue Cross and Blue Shield of NC		
	Cigna Healthcare		
	Oscar Health Plan of North Carolina, Inc		
	UnitedHealthcare	✓	
North Dakota	BCBS of North Dakota		C
	Medica	✓	
	Sanford		
Ohio	Ambetter (Buckeye Community Health Plan)		F
	Community Ins Co. (Anthem BlueCross and BlueShield)	✓	
	Antidote Health Plan of Ohio	✓	
	CareSource	✓	
	Medical Mutual	✓	
	Molina Healthcare	*	
	Oscar Buckeye State Health Insurance	✓	
	Oscar Health Ins. Corp of Ohio	✓	
	Paramount Insurance	✓	
	SummaCare	✓	
	UnitedHealthcare	✓	
Oklahoma	Ambetter of Oklahoma		A
	Blue Cross and Blue Shield of Oklahoma		
	CommunityCare		
	Medica		
	Oscar Insurance Company		
	Mending Health Plan	*	
	United Healthcare		

Appendix 1: Copay Assistance Diversion Policies in 2026 Marketplace Plans

State	Issuer	CAAP	Grade
Oregon	BridgeSpan		A
	Kaiser		
	Moda	*	
	PacificSource	*	
	Providence		
	Regence BlueCross BlueShield of Oregon		
Pennsylvania	*Ambetter Health of Pennsylvania		F
	*Capital Advantage Assurance (BlueCross)	✓	
	*Geisinger Health Plan (HMO)		
	*Geisinger Quality Options, Inc. (PPO)		
	*Highmark Blue Shield (PPO)(benefits group)	✓	
	Highmark Coverage Advantage (EPO) (Blue Cross Blue Shield)	✓	
	*Highmark Inc.	✓	
	Independence Blue Cross (Personal Choice PPO)	✓	
	Independence Blue Cross (Keystone HMO)	✓	
	Jefferson Health Plans (HMO)	✓	
	Oscar Health Plan of PA	✓	
	Partners Insurance Co (Jefferson PPO)	✓	
	UPMC Health Options	✓	
	UPMC Health Plan	✓	
Rhode Island	BCBS	✓	C
	Neighborhood Health Plan of RI		
South Carolina	Ambetter from Absolute Total Care	✓	F
	BlueCross BlueShield of South Carolina	✓	
	First Choice Next (Select Health)	✓	
	InStil Health	✓	
	Molina Healthcare	*	
	United Healthcare	✓	

Appendix 1: Copay Assistance Diversion Policies in 2026 Marketplace Plans

State	Issuer	CAAP	Grade
South Dakota	Avera Health Plans		C
	Sanford Health Plan		
	Wellmark BlueCross BlueShield of South Dakota	✓	
Tennessee	Alliant Health Plans		C
	Ambetter of Tennessee		
	BlueCross BlueShield of Tennessee	✓	
	Cigna Healthcare		
	Oscar Insurance Company		
	UnitedHealthcare	✓	
Texas	Ambetter from Superior HealthPlan		A
	Baylor Scott and White Health Plan	*	
	Blue Cross and Blue Shield of Texas		
	CHRISTUS Health Plan	*	
	Cigna Healthcare		
	Community First		
	Community Health Choice	*	
	Harbor Health		
	Imperial Insurance Companies, Inc.	*	
	Moda Health, Inc.	*	
	Molina Healthcare		
	Oscar Insurance Company		
	Sendero Health Plans, Local Nonprofit		
	UnitedHealthcare		
	Wellpoint		

Appendix 1: Copay Assistance Diversion Policies in 2026 Marketplace Plans

State	Issuer	CAAP	Grade
Utah	BridgeSpan Health Company	✓	F
	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	Anthem (Health Keepers, Inc)		A
	CareFirst BlueChoice		
	CareFirst BlueCross BlueShield (Group Hospitalization and Medical Services, Inc)		
	Cigna Healthcare		
	Kaiser Permanente		
	Oscar Insurance Company		
	Sentara Health Plans		
	UnitedHealthcare (Optimum)		
Washington	Ambetter (Coordinated Care)	*	B
	BridgeSpan Health Company	*	
	Community Health Network of Washington		
	Kaiser Permanente		
	LifeWise Health Plan		
	Molina	*	
	Premera Blue Cross		
	Regence BlueShield	*	
	UnitedHealthcare	✓	
	Wellpoint	*	

Appendix 1: Copay Assistance Diversion Policies in 2026 Marketplace Plans

State	Issuer	CAAP	Grade
West Virginia	CareSource		A
	Highmark Blue Cross Blue Shield West Virginia		
Wisconsin	Aspirus Health Plan	✓	F
	Anthem BC and BS (CompCare)	✓	
	CareSource (Common Ground Healthcare)	✓	
	Dean Health Plan	✓	
	Group Health Coop of South Central WI	✓	
	HealthPartners Insurance	✓	
	Medica Health Plans of WI	✓	
	MercyCare Health Plans		
	Network Health	✓	
	Quartz Health Benefits		
	Security Health Plan of Wisconsin	✓	
	United Healthcare	✓	
Wyoming	BCBS of Wyoming	✓	F
	United Healthcare	✓	

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. 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).

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.

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. 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 (*left*) is a simplified overview of how copay accumulator adjustment policies work for patients who use copay assistance.

Example 2 (*next page*) shows how each of the copay diversion 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 adjustor or other copay diversion 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 (*next page*) 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.

Scenario 3 (*next page*) shows how a variable copay program impacts the patient's out-of-pocket costs. The insurer/PBM adjusts the copayment for the prescription to match the total amount of copay assistance available; the PBM could divide the copay assistance by 12, with an even copayment

Example 2, Scenario 1: No Copay Accumulator

- Plan deductible: $4,600
- Annual out-of-pocket maximum: $8,550
- Monthly medication cost: $3,750
- Copay assistance total: $7,200
- Cost-sharing for specialty tier prescription: 50% *after deductible is met*

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	

Deductible is met Copay assistance limit is met Out-of-Pocket maximum is met

required each month ($600), or the PBM could collect the entire amount of copayment assistance upfront and leave the patient with a $0 copay for the remaining months of the plan year. Under this scenario, the insurer/PBM collects the total amount of copay assistance, and since the copayments have not counted toward the deductible, the patient would still be responsible for that amount for other health services. In total, the insurer/PBM could collect between $7,200 and $11,800.

Example 2, Scenario 2: Copay Accumulator

- Plan deductible: $4,600
- Annual out-of-pocket maximum: $8,550
- Monthly medication cost: $1,680
- Copay assistance total: $7,200
- Cost-sharing for specialty tier prescription: 50% *after deductible is met*

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	

Example 2, Scenario 3: Variable Copay ("Maximizer")

- Plan deductible: $4,600
- Annual out-of-pocket maximum: $8,550
- Monthly medication cost: $1,680
- Copay assistance total: $7,200
- Cost-sharing for specialty tier prescription: 50% *after deductible is met*

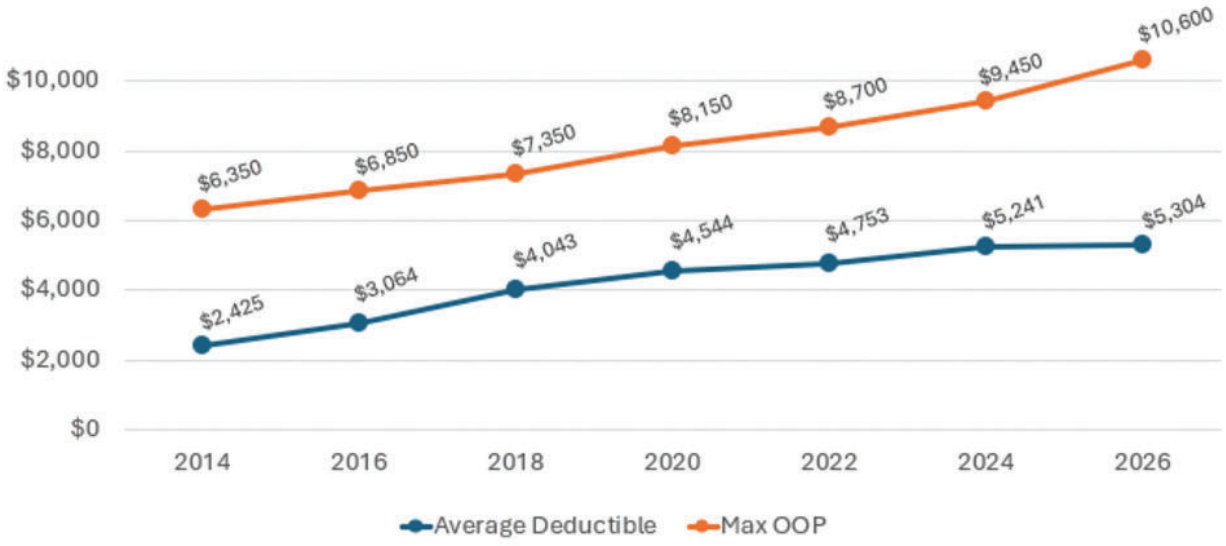
Scenario 3: Plan ***With*** a Copay Maximizer Program

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total	Insurer collects
Copay Assistance	$600	$600	$600	$600	$600	$600	$600	$600	$600	$600	$600	$600	$7,200	
Remaining Deductible	$4,600	$4,600	$4,600	$4,600	$4,600	$4,600	$4,600	$4,600	$4,600	$4,600	$4,600	$4,600		$7,200 to $11,800
Patient Pays	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$4,600	

Appendix 3: Shifting the Cost Burden to Patients

Since 2014, annual deductibles and the out-of-pocket limit for patients have continued to grow year after year. The Chart below shows the average deductible and out-of-pocket limit for individual marketplace plans from 2014 to 2026.

Individual Marketplace Plan Patient Out-of-Pocket Costs 2014-2026



Appendix 4: 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.
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.

Appendix 4: State Laws Banning Copay Diversion Policies

State	Copay Accumulator Language
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.
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.

Appendix 4: State Laws Banning Copay Diversion Policies

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.
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 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.

Appendix 4: State Laws Banning Copay Diversion Policies

State	Copay Accumulator Language
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.
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.
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.

Appendix 4: State Laws Banning Copay Diversion Policies

State	Copay Accumulator Language
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).
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.
North Dakota HB.1216 2025	When calculating an enrollee's overall contribution to any out-of-pocket maximum or any cost - sharing requirement for a prescription drug under the health benefit plan, the health benefit plan provides for the inclusion of any amount paid by the enrollee or paid on behalf of the enrollee by another person. This includes for a generic drug equivalent that enrollee has obtained access through prior authorization, step therapy, or exceptions or appeals process. The health benefit plan may not vary the out-of-pocket maximum or cost-sharing requirement, or otherwise design benefits accounting for the availability of a cost-sharing assistance program for a prescription drug. The requirements of this section do not apply with respect to the deductible of the health benefit plan until after the enrollee has satisfied the minimum deductible under section 26 U.S.C. 223.
Indiana HB.1604 2025	Requires an insurer or pharmacy benefit manager to apply the annual limitation on cost sharing to prescription drugs that: (1) are covered under a health plan; (2) are life-saving or intended to manage chronic pain; and (3) do not have an approved generic version. Provides that an insurer or pharmacy benefit manager may not directly or indirectly set, alter, implement, or condition the terms of health insurance coverage based in part or entirely on information about the availability or amount of financial or product assistance available for a prescription drug.

Appendix 4: State Laws Banning Copay Diversion Policies

State	Copay Accumulator Language
Maryland SB.773 2025	When calculating an insured's contribution to the coinsurance, copayment, deductible, or out-of-pocket maximum under the insured's health benefit plan, an entity shall include any discount, financial assistance payment, product voucher, or other out-of-pocket expense made by or on behalf of the insured for a prescription drug that: 1)is covered under the health plan, 2) does not have an AB-rated generic equivalent drug or interchangeable biologic preferred under the health plan formulary, or 3) has a generic or interchangeable biologic but the insured obtained coverage through prior authorization, step therapy, or the exception or appeal process. If the insured is covered under a high-deductible health plan, as defined in 26 USC 223, this does not apply to the deductible requirement of the high-deductible health plan. An insured receiving a discount, financial assistance, voucher must be made aware of the dollar amount and expiration date of the assistance. An entity may not set, alter, implement, or condition the terms of the health benefit plan coverage, based on the availability or amount of financial assistance for a prescription drug.
Iowa S.383 2025	A pharmacy benefits manager shall include any amount paid by a covered person, or on behalf of a covered person, when calculating the covered person's total contribution toward the covered person's cost-sharing. Any amount paid by a covered person for a prescription drug shall be applied to any deductible imposed on the covered person by the covered person's health benefit plan in accordance with the health benefit plan's coverage documents. If a covered person's policy, contract, or plan providing for third-party payment or prepayment of health or medical expenses qualifies as a high-deductible health plan under section 223 of the Internal Revenue Code, Senate File383,p.5 and a copayment, coinsurance, or deductible paid would result in the covered person becoming ineligible for a health savings account associated with the covered person's high-deductible health plan, subsection5 shall apply only after the covered person satisfies the covered person's minimum deductible.
New Jersey A.5217 2026	When calculating an enrollee's contribution to any applicable cost-sharing amount requirement, a carrier or third-party administrator shall give credit for the amount, or any portion thereof, of any cost-sharing amount paid by the enrollee or on behalf of the enrollee by another party. If a health benefits plan qualifies as a high-deductible health plan for which medical expenses are paid using a health savings account established pursuant to section 223 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.223), this subsection shall apply to a high-deductible health plan with respect to the deductible after the enrollee has satisfied the minimum deductible required under section 223, except for with respect to items or services that are preventive care pursuant to section 223(c)(2)(C) of the federal Internal Revenue Code (26 U.S.C. s.223), in which case the requirements of this subsection shall apply regardless of whether the minimum deductible under section 223 has been satisfied.

Appendix 4: State Laws Banning Copay Diversion Policies

State	Copay Accumulator Language
Puerto Rico S.1658	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.

www.theaidsinstitute.org

The AIDS Institute maintains integrity in its program and policy priorities through independence from corporate partners and sponsors.

The content, research, and views represented in this report are those of The AIDS Institute.

Stephanie Hengst, Manager, Policy & Research
The AIDS Institute

Rachel Klein, Deputy Executive Director
The AIDS Institute

Michael Ruppal, Executive Director
The AIDS Institute

Published February 2026