Project CALLS
Creating Alternatives to Limiting and Lacking Services

Copay Accumulator Adjusters Create Confusion, Obstacles for Consumers

BY MARK HOBRACZK, STAFF WRITER

Health insurers continue to develop new methods to limit access to care for members of the bleeding disorders community. Through Project CALLS, Hemophilia Federation of America has collected more than four years of reports from consumers that help to identify these new barriers.

HFA is using this data to develop resources to educate decisionmakers and community members about the harm caused to consumers by these restrictive insurance company practices. The following case study describes one of the insurance challenges recently reported to HFA through Project CALLS and suggests some ways consumers and HFA can work to ensure continued access to care.

A Recent Case Study

A young adult male with hemophilia A aged out of his parents' group health plan after age 25. He initially obtained individual platinum-tier coverage offered by the Affordable Care Act Marketplace in his home state. During this time, this enrollee had received cost-sharing assistance from the manufacturer for his factor product. Because this assistance covered his out-of-pocket (OOP) costs, he decided to switch to the bronze plan for the 2020 plan year, since it had the lowest premium.

Before switching plans, the enrollee did his homework to prevent any disruption in care. He confirmed that the provider network for the bronze plan included his physician and providers. He also made sure the new formulary covered the medications he required.

He learned from HFA presentations that health plans were increasingly using copayment accumulator adjusters to contain costs. These accumulators do not allow the value of an enrollee's third-party assistance to be applied to the enrollee's annual cost-sharing obligations. As a result, the enrollee could be forced to pay the full $8,150 amount of the annual deductible under the bronze plan (which is the same as the annual out-of-pocket limit), despite receiving assistance.

This greatly concerned the enrollee and so he also took affirmative steps to determine whether the plan options available to him would apply an accumulator. He went into the local plan office shortly before the end of open enrollment but received conflicting information. Lower-level employees assured him the plan would not apply accumulators. However, a regional manager subsequently stated that the plan would start applying accumulators "across-the-board" for the 2020 plan year.

The enrollee never received any written notice confirming his plan would apply an accumulator. Instead, he was told by the office that the language could be found in "plan documents". On his own, the enrollee was able to find such language buried on page 123 of a 203-page document. The language in that document merely states that the health plan would apply accumulators at the plan's "discretion."

As a result, the enrollee decided to go ahead and sign-up for the bronze plan (since it had much lower premiums with only a slightly higher OOP limit). However, when he notified the manufacturer that an accumulator might be applied to his plan, the manufacturer stopped sending checks to the enrollee's insurer to cover his OOP costs.

The enrollee was very confused by the conflicting information he received from the insurer, which forced him to seek out emergency sources of funding (such as family loans) in the event he is forced to incur the $8,150 deductible. Adding to this confusion is the fact that he had not been billed for any OOP cost following his first shipment of medication in 2020. He is requesting assistance from HFA on how to proceed.

Questions that arise with this case:

1. Should the enrollee ask the manufacturer to resume paying his cost-sharing assistance? Does it make sense to make such a request before the plan clarifies whether or not it is applying an accumulator?
2. Because the plan is being offered in a federally-facilitated ACA Marketplace, it must follow federal rules that prohibit midyear formulary changes that substantially increase OOP costs without "reasonable notice." Thus, is it even permissible for the plan to apply accumulators for 2020 since they have not issued advance notice to subscribers? Will Centers for Medicare and Medicaid Services enforce the prohibition against midyear formulary changes in cases such as this one? Or will CMS conclude that the discretionary language appearing on p.123 of the health plan document satisfies the "reasonable notice" requirement?
3. Is the health plan exercising discretion to apply accumulators only for its highest-cost enrollees? Would that violate the ACA's anti-discrimination provision? Will CMS enforce those anti-discrimination provisions?
4. Does the health plan intend to apply accumulators starting with the 2021 plan year, with clearer notice? With the same notice?

How HFA Uses Project CALLS to Help the Bleeding Disorders Community

- Educate community members about how to identify and receive clear notice of accumulators prior to plan selection.
- Educate community members about their rights when accumulators are applied.
- Educate community members about other sources of copay assistance that may not be subject to accumulators (e.g., third-party charitable assistance).
- Use this case study as an example of how insurers play "hide the ball" with accumulators and how such practices can lead patients astray, even when patients take advance steps to identify whether their cost-sharing assistance will be credited towards their cost-sharing obligations.

Have you or family member experienced an insurance issue?

Share your experience at www.hemophiliafed.org/projectcalls by calling (202) 836-2530.