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OPINION

Should Double Charging Patients for Medication be Legal?

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Imagine going with a friend to your favorite restaurant. When the bill comes, your friend generously offers to cover it—and plops down a gift card he received for Christmas. The waiter charges the card without issue. But as you get up to leave, the waiter demands more cash.

"What do you mean?" you stammer, flummoxed. "We just paid!"

"You're not supposed to benefit from your friend's gift card," the waiter curtly responds. "We also need you to pay the check, in cash."

That scenario sounds ridiculous—and it is. Restaurants aren't allowed to double charge patrons. But in the health insurance industry, double charging is not only legal, it's becoming standard practice.

Over the summer, the Department of Health and Human Services issued a rule allowing health insurers to implement "accumulator adjustment programs," which allow insurers to effectively double charge customers for drugs. Several states have banned these programs, which seriously harm patients' health. The feds should follow suit.

First, some background. Every year, pharmaceutical companies offer billions of dollars in coupons, which help patients afford the co-pays and co-insurance required by most plans. Without these coupons, many low- and even middle-income Americans would struggle to afford certain medicines.

These copay coupons essentially allow drug companies to charge different prices within health plans, in addition to charging different prices across insurers. This benefits poorer patients who'd otherwise struggle to afford the out-of-pocket costs. Economists agree that allowing prices to vary across consumers maximizes the number of people who can afford a product.

Consider a hypothetical patient, Susie. She needs a cutting-edge, $10,000-per-month cancer treatment. Her insurance has no deductible and covers 75 percent of that tab.

Susie, and most Americans, would struggle to come up with $2,500 every month. So to ensure she can fill her prescription, the drug's manufacturer might offer a coupon that covers 90 percent of Susie's out-of-pocket obligations. With this monthly coupon, Susie would spend just $250 of her own cash each month.

Traditionally, health insurers have counted these manufacturer coupons towards patients' deductibles and out-of-pocket maximums. Once individuals hit this annual out-of-pocket maximum—which is around $8,500 for most in 2021—insurers start covering the full cost of any additional care.

Between her coupons and her own contributions, Susie would hit her annual out-of-pocket maximum in less than four months. After that, her insurer would cover her full treatment costs for the rest of the year.

Unfortunately, thanks to accumulator adjustment programs, some insurers have stopped counting coupons towards out-of-pocket maximums. They still pocket the coupons, but only count patients' own cash contributions when calculating deductibles and out-of-pocket spending.

As a result, patients keep paying larger bills, for longer. Our hypothetical patient, Susie, would continue to shell out $250 each month, never reaching her out-of-pocket maximum.

Defenders of these programs allege that if insurers count coupons, patients will choose brand-name drugs over cheaper generic counterparts. But this isn't true. A comprehensive analysis by IQVIA, the main data supplier on the industry, found that coupons used on brand-name medicines that have generic competitors represent just "0.4% of the total commercial market volume."

Defenders of accumulator adjustment programs also warn that drug companies will raise prices for insurers if they can simply lower prices for poor consumers afterwards with coupons. But allowing different consumers to pay different prices maximizes uptake of medicines, and thus boosts patient health.

Indeed, accumulator adjustment programs force many patients to stop filling their prescriptions. For example, after one large insurer imposed an accumulator adjustment program for autoimmune medications, refill rates dropped 12 percent within just one year, according to a 2019 study from AMCP Nexus. The number of patients who stopped taking the drug entirely increased 400 percent. When patients cease treatment, they get sicker. Drug non-adherence accounts for about 10 percent of hospitalizations, according to a review published in the Annals of Internal Medicine. Annually, it causes some 125,000 deaths and costs the health care system up to $289 billion—much of which is borne by taxpayers through public insurance programs.

Arizona, Illinois, Virginia and West Virginia have all banned accumulator adjustment programs. The federal government would be wise to follow their lead. These programs pad insurers' profits—at the cost of patient health and tax dollars.

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