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Are Manufacturer Drug Coupons and HDHPs a Good Fit?

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In our last blog past, we discussed the recent rule finalized by Health and Human Services regarding the calculation of the annual cost-sharing limits for health plan participants who receive financial assistance from drug manufacturers. Effective for plan years beginning on or after January 1, 2020, if a participant uses a manufacturer drug coupon to purchase a drug but there is no generic equivalent available or the generic equivalent is determined not to be medically appropriate, the financial assistance provided by the manufacturer must be counted towards the ACA out-of-pocket maximum. This new rule applies to all non-grandfathered group health plans, including self-insured plans.
Many large self-insured employers have begun to utilize manufacturer drug coupons as part of their prescription drug plans. These coupon programs are referred to as "copay assistance programs" and typically apply to high-cost specialty drugs for which a generic is not available. Under these programs, when a health plan participant purchases the drug, the participant pays a minor copay (e.g., $15) or might not pay a copay at all. If the drug was purchased normally under the employer plan without the copay assistance, the participant might have to pay hundreds of dollars more for the same drug.

In the past, most employer-sponsored health plans did not apply the amount of financial assistance provided by drug manufacturers to either the participant's deductible or the participant's out-of-pocket maximum. The reason behind this rule stems from the basic tenant that if a participant is not responsible for the payment for a product, the dollar value of the product should not be added to a deductible or out-of-pocket maximum. It is treated merely as if the participant received a free sample of the drug from a physician.

Applying copay assistance programs to high deductible health plans ("HDHP") can become complicated. Although the Internal Revenue Service has allowed the use of prescription discount cards in conjunction with HDHPs, many practitioners view a copay assistance program as more than just a discount card. Frequently, participants pay nothing or virtually nothing for a drug that is part of a copay assistance program, and the copay assistance program is operated by the same PBM / TPA that operates the employer's regular prescription drug program. Therefore, a copay assistance program is reasonably viewed as impermissible coverage for an HDHP – meaning that a participant enrolled in an HDHP could not utilize the copay assistance program until after the HDHP deductible has been satisfied for the year.

However, the more troubling aspect of the new HHS rule discussed above is the way in which the new rule

impacts HDHPs which are intended to be paired with a health savings account. For participants to be HSA-eligible, HDHPs must satisfy two separate out-of-pocket maximum rules – the ACA limit and the HDHP limit. For 2019, the ACA limits are $7,900 for self-only and $15,800 for family coverage, while the HDHP limits are $6,750 for self-only coverage and $13,500 for family coverage. Therefore, commencing in 2020, HDHPs may be required to credit the dollar value of copay assistance programs for purposes of the ACA limit, but not credit it for purposes of the HDHP limit. Then, if the ACA limit is reached, but the HDHP limit is not reached, it's unclear whether the plan could then pay claims at the 100% level without the HDHP limit being satisfied.

It is our understanding that the DOL and IRS are discussing the above issues internally, and guidance regarding the application of the HHS rule to self-insured plans and HDHPs may be issued in the near future.