Alliance of Specialty Medicine

20TH ANNIVERSARY

Sound Policy. Quality Care.

November 3, 2020

Lewis G. Sandy, MD, FACP
Executive Vice President
Clinical Advancement
UnitedHealth Group
9900 Bren Road East
Minnetonka, MN 55343

Dr. Sandy:

The Alliance of Specialty Medicine (the "Alliance") represents more than 100,000 specialists and subspecialists who are committed to improving access to specialty medical care through the advancement of sound health policy. The undersigned members of the Alliance are deeply concerned about the "Accumulator Adjustment Medical Benefit" protocol, which will go into effect for UnitedHealthcare (UHC) commercial members on January 1, 2021.

Physician-administered medications are key to the treatment and management of some of the most serious medical conditions. These medications can also be expensive, which means patients often need assistance with out-of-pocket costs. In an attempt to prevent patients from using copay assistance, UHC, like many other insurers, has begun to use so-called copay accumulators, which prevent copay assistance funds from being applied towards patients' deductibles and out-of-pocket maximums.

The Accumulator Adjustment Medical Benefit protocol will require physicians to report to UHC whether a patient used copay assistance for a medical benefit drug. Given the mandatory nature of the protocol, the physician presumably will not be reimbursed for the drug claim until the information is provided to UHC via the new "Pharma Coupon" tab in its provider portal. It is unclear whether UHC would also delay payment for services provided and billed in conjunction with the drug claim. UHC would rely on this information from the physician to enforce its copay accumulator against the patient. According to UHC's Frequently Asked Questions on the new protocol, if the patient ultimately cannot use the coupon, "the care provider who submitted the original claim is expected to sign into the online claims portal and enter a coupon value of $0 and the applicable member cost share, so we know the coupon wasn't used." UHC would then ensure that the patient's out-of-pocket expenditure level reflects this fact. This new administrative work, which will not be reimbursed, takes yet more time away from patient care.

As a general matter, we oppose copay accumulators, particularly as applied to medicines that have no low-cost therapeutic equivalents – which most of the specialty drugs subject to this policy do not. In those cases, the

presence of copay assistance does not drive brand adherence; rather, it makes the difference between patients being able to access their medicine, or not. Research by the University of Southern California confirms this, finding that a majority of copay coupons "were for drugs with no generic substitute—including 12 percent for drugs with no close therapeutic substitute of any kind. These results suggest that most copay coupons are not affecting generic substitution, and many may help patients afford therapies without good alternatives."[1] This is particularly true given the rapid growth of high deductible plans, which shift large, upfront, out-of-pocket costs onto patients. Currently, approximately a quarter of all adults aged 18-64 with employment-based coverage are enrolled in a high-deductible health plan without a health savings account.[2] Indeed, the effect of copay accumulators on patient adherence is so detrimental that Virginia, West Virginia, Illinois, Arizona, and Georgia have enacted legislation limiting or outright banning the use of copay accumulators, with other States sure to follow.

It is our understanding that UHC has committed to the use of copay accumulators despite the detrimental effect on patient adherence. However, we would be remiss not to note our strong objection to drawing physicians into the implementation of these harmful programs. Physicians are accustomed to providing extensive amounts of information to insurers and pharmacy benefit managers to ensure that patients can access medically indicated care. However, this is the first time that an insurer would enlist physicians to provide information designed to *limit* access to necessary clinical care. Such a henchman's role is not appropriate for the physician, who serves as an advocate for the patient. Requiring physicians to essentially "tattle" on patients is an egregious violation of the doctor-patient relationship and the ethical principles that underlie the practice of medicine, particularly in cases where the physician knows a patient will not be able to access the medicine unless (s)he can access the full value of available copay assistance.

In light of the above, we urge you not to proceed with the Accumulator Adjustment Medical Benefit protocol. We appreciate your consideration of these viewpoints. Should you require additional information, please do not hesitate to contact any of the undersigned organizations.

Sincerely,

American Association of Neurological Surgeons
American College of Osteopathic Surgeons
American Gastroenterological Association
American Society of Cataract and Refractive Surgery
American Society of Plastic Surgeons
American Society of Retina Specialists
American Urological Association
Coalition of State Rheumatology Organizations
Congress of Neurological Surgeons

[1] University of Southern California, Leonard D. Schaeffer Center for Health Policy & Economics, "Prescription Drug Copayment Coupon Landscape" by Karen Van Nuys, PhD, Geoffrey Joyce, PhD, Rocio Ribero, PhD, and Dana P. Goldman, PhD (February 2018).

[2] Centers for Disease Control and Prevention, National Center for Health Statistics, Data Brief: "High-deductible Health Plan Enrollment Among Adults Aged 18–64 With Employment-based Insurance Coverage" (August 2018).