THE INSIDER'S GUIDE TO

Drug Formularies & Medication Benefits

Patient Advocate Foundation

KEY TERMS

Brand-Name Drugs | A drug marketed under a specific trade name by a drug manufacturer. These drugs are still under patent protection, making the original manufacturer the only company able to make this medication.

Co-Insurance | The percentage of the negotiated cost of your prescription drug that you pay after you have finished paying your deductible. Your health plan pays the rest.

Co-Pay | The dollar amount you pay for your prescriptions after you have finished paying your deductible.

Deductible | The amount you pay for prescriptions before your health plan begins to pay.

Drug Formulary | A list of medications preferred by your health insurance and prescription benefit plan.

Generic Drugs | A drug with the same active ingredient as the brand-name drug, which the FDA has deemed equally safe and effective. Generic drugs usually cost less than brand-name drugs.

Non-Preferred Drugs | Drugs that work just as well as other medications already on the list but are often newer brand names. Since they're new, they might be more expensive for your insurance company to cover.

Preferred Drugs | Effective treatments that come at a reasonable price for your insurance company, often generic or older brand-name drugs. Because they are more cost-effective for your insurance, you'll typically pay less for preferred drugs. This might mean a lower co-pay or co-insurance compared to non-preferred options.

Tiers | Coverage levels of your formulary, often having different out-of-pocket costs.

Over 60% of adults 18 or older in the US take at least one prescription medication, according to a 2021 CDC survey. The number of prescriptions is likely higher for many, especially if you have a critical or chronic illness. Since most people in the US have some kind of health insurance, understanding the ins and outs of how prescription coverage works has never been more important. This publication breaks down the complexities of medication formularies and benefits and aims to help you take control of your coverage and costs.

Table of Contents

DRUG FORMULARIES

What is a Drug Formulary?

A drug formulary (commonly referred to as a formulary or Preferred Drug List or PDL) is a list containing all the prescription drugs, both generic and brand-name, covered by your health insurance plan. This isn't a list of all medications available, but rather the ones your plan agrees to help pay for. Your insurance benefits may not cover any medication not included on this list. Whether you have insurance through a private insurance company, Medicare, Medicaid, or Tricare, your insurance plan keeps a list of drugs it will pay for.

Your formulary groups medications into categories called tiers. The number and names of these tiers can vary depending on your specific plan. The key thing to know is that each tier has a different cost: medications in lower tiers typically cost you less out of pocket than those in higher tiers.

The Importance of Your Drug Formulary

You should know how your drug formulary works for these reasons:

1

To be aware of which medications and pharmaceutical treatments are covered by your insurance benefits.

Your formulary gives you a complete list of every drug covered by your plan and where it falls within the tiers. During plan enrollment, this information will help you decide which health plan option is best for you based on your medical needs. If you know you will need a certain medication, you can compare drug formularies from several health plans and choose a plan where that drug is covered.

2

To determine how much those drugs are going to cost you.

You need to know how much each drug will cost you under your benefits. Your drug formulary will place each drug into a specific tier that you then match with your list of co-pays and co-insurance for that tier. For example, a generic drug listed under Tier 1 may mean you have a $20 co-pay at pickup, while a preferred brand-name drug under Tier 2 could have a $50 co-pay. Depending on your actual drug coverage, each medication will require you to pay a co-pay or co-insurance amount to take the medication home.

3

To know upfront if your medication requires any special treatment, or has any limitations or necessary paperwork for you or your provider to complete.

In addition to showing the tier of the medication, the formulary will also show if a drug has any special conditions attached to it. For example, your medication may require your treating provider's office to submit a prior authorization form to the insurer before they will cover it. A quantity limit means you can only get a certain number of the drug due to safety concerns. If you need more than the limit, your provider needs to get a prior authorization. *(We will discuss these special requirements more on page 8.)*

Most drug formularies have a key that will tell you what the various symbols mean. You can often find this key at the beginning or end of the drug formulary, or sometimes near the bottom of each page.

How to Read Your Drug Formulary

While each insurance provider has its own style and layout for its drug formulary, the basic elements are similar.

We have highlighted **six key elements** of a drug formulary to help you better understand yours.

1. The drug's name
2. The tier the drug is in
3. Restrictions or notes
4. Categories based on what the medication treats
5. Generic drugs in all lowercase letters and name-brand drugs in all capital letters
6. Acronyms key

DRUG FORMULARY EXAMPLE

4 → CARDIAC DRUGS

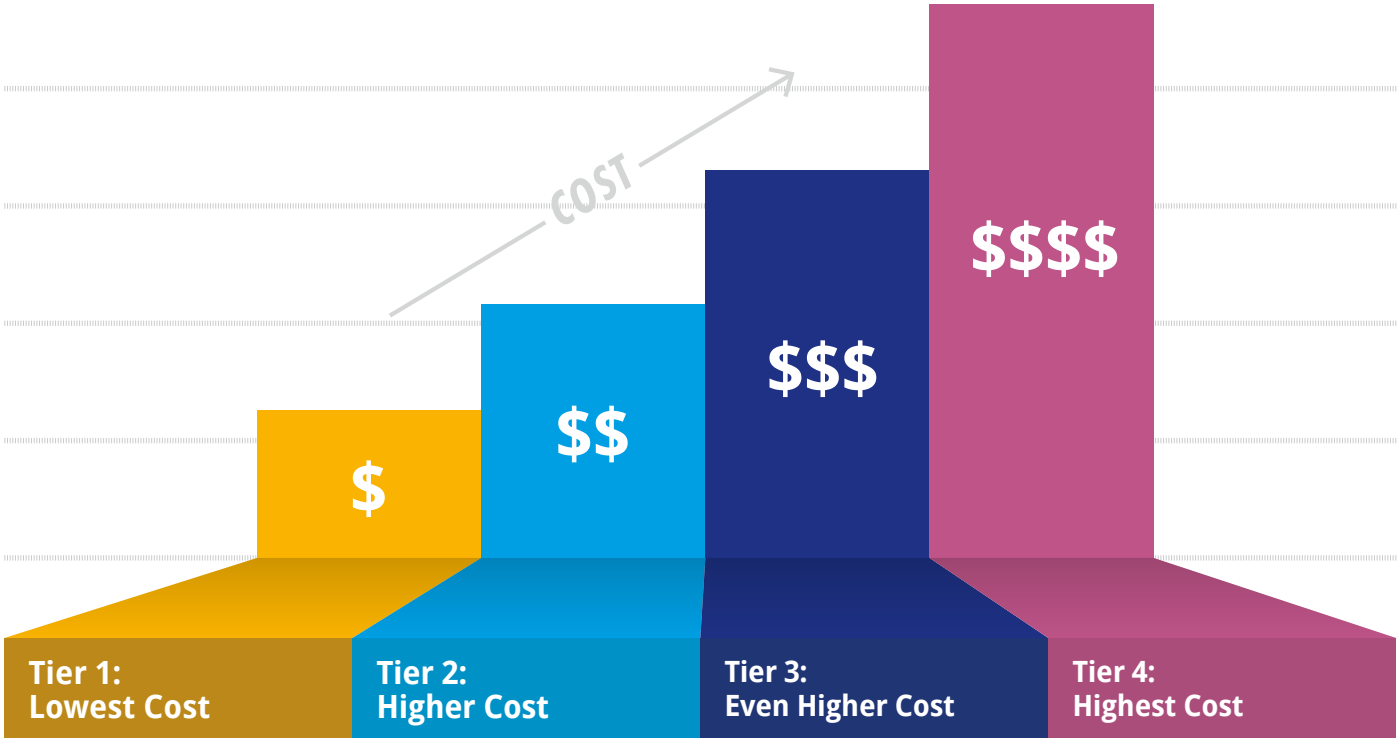
1 → Drug Name	2 → Tier	3 → Notes
heart drug 1	1	
heart drug 2	1	
5 → HEART DRUG 3	4	ST, QL
HEART DRUG 4	3	PA
heart drug 5	2	

DIABETES DRUGS

Drug Name	Tier	Notes
DIABETES DRUG 1	3	PA
DIABETES DRUG 2	4	PA
diabetes drug 3	1	
diabetes drug 4	1	

6 → ST - Step Therapy | PA - Prior Authorization | QL - Quantity Limits

How Your Tiers Connect to Cost



Tier 1: Lowest Cost

Holds the cheapest prescription drugs available to you, typically limited to generic drugs. Generic drugs are just as safe as brand-name drugs. The only difference between the two is the name and the cost savings. Some plans include cheaper brand-name drugs under Tier 1.

Tier 2: Higher Cost

More expensive generic drugs and preferred brand-name drugs occupy this tier. If you must take a brand-name drug, try to work with your doctor to choose an appropriate one from Tier 2, as they are the most affordable.

Tier 3: Even Higher Cost

Non-preferred and expensive brand-name drugs are typically in this tier. Your plan may include drugs in this tier that are new to the market. Most often, these drugs will leave you with a significant out-of-pocket cost.

Tier 4: Highest Cost

Usually occupied by brand-name and specialty drugs. These drugs typically do not have specific co-pays; instead, you'll pay a percentage of the total cost negotiated between the health plan and the manufacturer of the medication.

How is My Formulary Decided?

Each health insurance provider uses an independent panel of experts to choose which drugs will go on the formulary. This is known as a pharmacy and therapeutics (P&T) committee. The committee is made up of pharmacists, physicians, and other clinical experts.

The committee meets regularly to manage and update the formulary. They will discuss new drugs, safety data, clinical trial results, and doctor's recommendations to keep the formulary up to date. As a result of these regular meetings, your drug formulary may change at any time. The committee is only in charge of deciding which drugs will be on the formulary. Your health insurance company determines how much you will pay for the selected drugs.

Is Every Drug Formulary the Same?

No. And the difference between them can result in thousands of dollars in costs.

Some differences that you may run across include:

- The number of tiers. Usually, this ranges from 3 to 5.
- The name for each tier. Some may list the number of the tier, while others may use words to identify each tier, like "Preferred Drugs," "Non-Preferred Generic," or "Specialty Drugs."
- Drug tier levels. The drugs classified on one formulary as a certain tier may be listed within a more expensive or cheaper tier on another formulary.
- Certain restrictions (step therapy, prior authorization, quantity limits). These may be found on one formulary but may not exist on another.

Although drug formularies can vary dramatically, all plans agree that the medications on a formulary must meet

Food and Drug Administration (FDA) safety standards. The FDA is a US government agency that regulates drug testing, labeling, and safety.

Can My Drug Formulary Change?

Surprisingly to most insurance consumers, formularies change often. As the FDA approves new drugs and more information about new uses for current drugs becomes available, the P&T committees meet to review and adjust their drug formularies.

This means that drugs can be added or removed from the drug formulary at any time. They can also move specific medications from one tier to another depending on several factors.

Some insurance companies might proactively notify you about medication tier changes. Others may not, leaving it to the pharmacy to inform you at the time of dispensing.

What Are Some Reasons Your Drug Formulary May Change?

- The FDA approves a new medication.
- The FDA approves an existing medication to treat a different diagnosis.
- A medication is withdrawn from the market for safety reasons.
- A medication becomes available without a prescription. Note: Over-the-counter drugs are not typically covered under prescription drug plans.
- Generic versions of a brand-name drug become available.

Where Can I Find My Formulary?

You can find a copy of your drug formulary on your health insurance company's member portal or website. The online drug formulary is the most current version available to you and is updated when changes occur. Most health insurance websites will either have the drug formulary listed so you can easily find it or will have a search bar where you can type in "drug formulary" or "drug list" to find it. Be sure that you are looking at the formulary that matches your specific plan as insurance companies frequently offer different plans to customers.

You can also request a printed copy by contacting your plan at the member services phone number listed on your health insurance card. Keep in mind that a printed drug formulary will not reflect any changes that can happen during the year.

Because your drug formulary can change at any time, you should check it regularly to ensure your prescriptions are still covered.

Know Your Drug Formulary Restrictions/Utilization Review

As discussed above, medications in your formulary will have coverage requirements or limits before insurance covers them. This practice is often called Utilization Review. Some of the methods include prior authorization, quantity limits, and step therapy.

PRIOR AUTHORIZATION

Prior authorization (PA) requires that your doctor obtain approval from your health insurance plan before you can have insurance coverage for certain medications. If your provider does not seek approval before prescribing you a restricted drug, your plan will not cover the medication. If that occurs, the pharmacy will require you to pay the total retail cost of the medication before filling the order.

The following drugs are examples of medications that can require PA:

- Brand-name medications that are available as generic drugs
- Expensive drugs
- Drugs that can be used for cosmetic reasons
- Drugs that may be harmful when combined with other drugs
- Drugs that can be abused or misused

QUANTITY LIMITS

Quantity limit (QL) restricts the amount of a particular drug your plan will cover over a period of time. For example, you might be prescribed a drug that requires you to take 2 tablets a day, or 60 tablets per month. If your plan has a quantity limit of 30 tablets per month, they will only cover half of your prescription. If this happens, ask your provider to contact your health insurance plan to request approval for the increased amount. You can also talk with your provider about changes to the dosages or selecting a different medication that provides the same medical benefit.

STEP THERAPY

Step therapy (ST) is a process that ensures you try lower-cost, equally safe, and effective drugs before your insurance plan covers a higher-cost prescribed drug.

Here is how the system works:

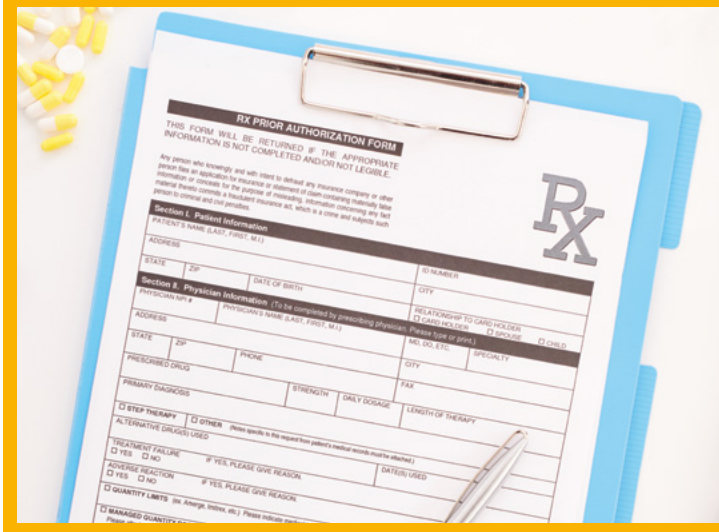
- Your provider prescribes a medication that requires step therapy, as listed in your formulary.

- Your pharmacist receives the prescription and enters it into the claim system.
- The claim system looks back at your claims history to see if you have had a prescription filled recently for a lower-cost alternative drug.
- If an alternative drug prescription is found, that claim for the drug requiring step therapy will be approved.
- If there is no history of an approved alternate drug, the claim will be denied because it doesn't meet the step therapy requirement.
- You or the pharmacist can then contact your physician to see if an alternative drug is acceptable.

  Option 1 | You and your provider can discuss an alternative for the prescribed medication.

  Option 2 | Your provider can submit documentation along with an authorization request to your insurer to ask for an exception if you've decided together that the drug prescribed is the best treatment.

- A notification will be sent by the insurance company to both you and your provider with the decision. This review typically takes between five and 10 business days. You may qualify for an expedited review if your provider feels that your health could be seriously harmed without access to the requested medication. Your provider needs to indicate this on the documentation they send with the request. If you qualify for an expedited review, the insurance company will respond within 72 hours.



Pharmacy Benefit Managers (PBMs)

Most health plans contract with a third-party company to administer their drug formulary. This third party is called a pharmacy benefit manager, often shortened to PBM. These PBMs work with drug manufacturers, wholesalers, and pharmacies to save insurance companies money. They do this by negotiating the prices of medication with pharmaceutical manufacturers. They also help administer the utilization management programs discussed above. While they aim to bring costs down, PBMs can influence how much you pay for prescriptions through things like pharmacy networks or how your formulary is designed. Additionally, PBMs might limit which pharmacies you can use or make it harder to get certain medications, especially newer or more expensive ones. In recent years, the existence of PBMs has become controversial. Some see them as a way to control costs, while others worry they may limit access to important medications or prioritize profits.

Co-Pays and Co-Insurance

These are the cost-sharing amounts that you will pay for your medication after your deductible has been met. Co-pays (also called co-payments) are a flat-dollar amount and co-insurance is a percentage of the drug's cost. These amounts are specific to the tier assigned to each medication and go up as the tier level goes up.

Prescription Drug Deductible

A prescription drug deductible is the amount that you must pay before your health insurance will begin making any payments toward covered prescriptions. Some health insurance plans have this cost included with all other medical-related expenses, while others do not.

If your plan combines your medical and prescription drug deductibles, you can pay the required amount with any covered medical-related expense.

Don't focus solely on your co-pays/co-insurance amount. Remember, you must pay your deductible first before you are subject to co-pays or co-insurance. For example, if your prescription drug deductible is separate from your medical deductible, you would need to pay the required amount solely for prescription drugs before your insurance begins paying for your medications.

The Importance of Your Deductible

Let's say that the same drug costs $100 on Plan A and $120 on Plan B. Plan A is obviously the best choice, right? Not necessarily. There are several factors you need to be aware of when choosing a health insurance plan. One of the bigger ones is the deductible. This amount can vary greatly between plans. Some deductibles are in the hundreds whereas others are in the thousands. Typically, the less you pay on your monthly premium, the higher your deductible will be.

Armed with this information, if Plan B has a deductible that is $200, and Plan A's is $1000, you would be better off going with Plan B and paying a little more for the medication now, to ultimately save hundreds of dollars on current or future medications.

Prescription Drug Out-of-Pocket Maximum

This cost is the maximum amount of money that you would have to spend in your plan year before your health insurance plan will cover 100 percent of all costs. Like deductibles, some plans have this as one amount for all medical-related expenses, while other plans require that this maximum be separate for prescription drugs and other medical services.

Choosing Your Pharmacy

Each health plan allows you to get your medications from various approved pharmacies called in-network pharmacies.

To find out what pharmacies are considered in-network, you can call your insurance company using the phone number listed

Helpful Resources to Research the Costs of Medications

Medication cost finders, like GoodRX and WellRX, can help you determine the lowest price of a medication. These websites compare prescription prices at different pharmacies near you. Some may only provide prices at participating pharmacies such as well-known nationwide chains. They can also help connect you to free digital/printable medication coupons. However, in most cases, these coupons cannot be used in conjunction with your insurance. So, purchases made with a coupon from these websites will most likely not count toward your deductible.

You can also use services like Amazon Pharmacy to check the price of your medication(s). They accept most insurance and offer mail-order medications.

on your insurance card or visit your insurer's website. If you prefer a particular pharmacy, check to see if it is an in-network pharmacy before you submit a medication to be filled at that location.

If you still choose to go to an out-of-network pharmacy, you will likely pay extra costs and in some cases will be asked to pay the full amount if your insurance does not offer any out-of-network benefits. Also, out-of-network pharmacies may require you to pay upfront and then submit reimbursement paperwork yourself to your insurance company.

Networks can change throughout the year, so your current pharmacy may not still be in the network the next time you visit.

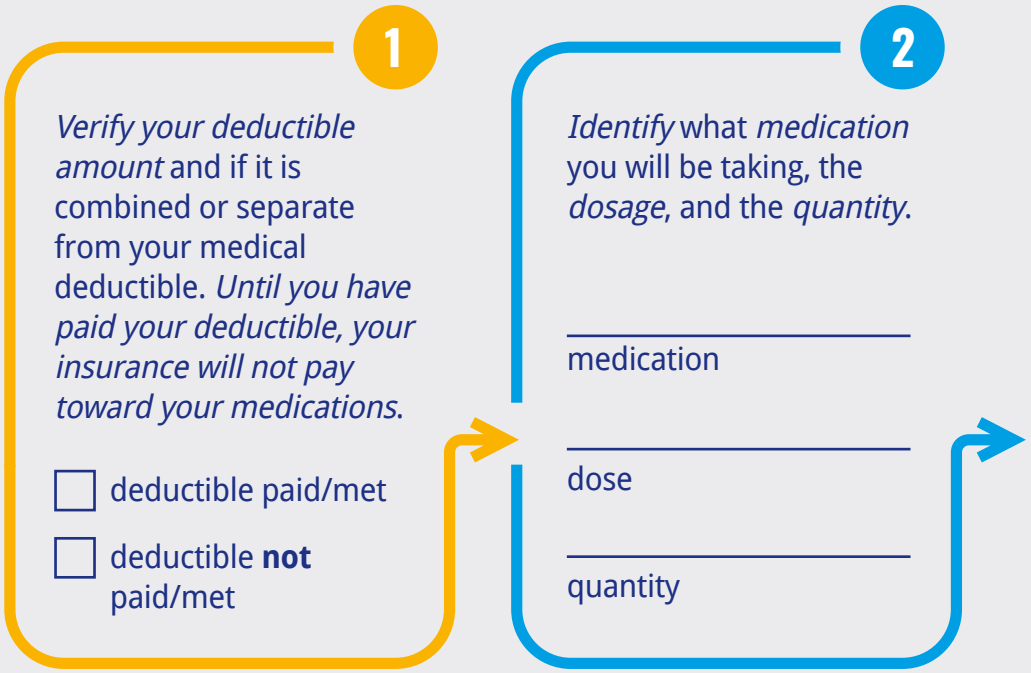
The Difference Between Brand-Name Drugs and Generic Drugs

The main difference between generic and brand-name drugs boils down to two main factors: ingredients and cost.

Brand-name drugs are developed by a drug company that goes through a lengthy process of research, testing, and getting approval from the FDA to bring the drug to market. The brand-name drug will contain

HOW TO ESTIMATE YOUR MEDICATION COSTS

Use our step-by-step example guide to learn how to use your drug formulary to figure out how much you'll pay for your medications.



a specific active ingredient responsible for the medication's effect. Brand-name drugs are patent-protected, meaning the original manufacturer is the only company able to make this medication.

Once the patent on a brand-name drug expires (typically after 20 years), other manufacturers can create generic versions. Generic drugs contain the same active ingredient and amount as the brand-name drug, but they may use different inactive ingredients like fillers, flavorings, or preservatives. These inactive ingredients don't affect the medication's effectiveness, but they might cause slight variations in things like taste or color. Because generic drugs don't require the same level of research and development as brand names, they are significantly cheaper to produce. Generics typically cost a fraction of the price of brand-name drugs.

Both generic and brand-name drugs must go through rigorous testing to ensure they are safe and effective for their intended use. The FDA approval process for generics focuses on proving they are bioequivalent to the brand name drug, meaning they work the same way in the body.

3

Look up your medication in your plan formulary to see *what tier* it is on and if it has any restrictions. *See how much your plan requires you to pay* based on what tier your drug falls on, *noting whether it's a co-pay or co-insurance*.

_____
tier

_____
$ / co-pay or co-insurance

4

If you have a co-insurance, research the average negotiated price of that medication using online tools, or speak to your pharmacist. You can also call your insurer or use their cost calculator tools.

_____
$

5

With the average price in hand, bust out your calculator to estimate your cost at an in-network pharmacy.

_____
$

Importance of Open Enrollment

If you find you are not happy with your current formulary, take advantage of your next open enrollment to make changes. Open enrollment is the time each year when you can sign up or update your health insurance coverage. It is a good idea to compare potential health plans before choosing next year's plan to ensure it is the best and most affordable option for you.

If you're shopping for a new health insurance plan, you can generally find a link to the formulary on the summary of benefits and coverage (the snapshot of important details about the health insurance plan). Insurers have a requirement to make this information available during open enrollment, so you can view a copy during your plan decision process.

SUMMARY OF BENEFITS AND COVERAGE EXAMPLE

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services
Insurance Company 1: Plan Option 1

Coverage Period: 01/01/2022-12/31/2022
Coverage for: Family | Plan Type: PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, [insert contact information]. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.[insert].com or call 1-800-[insert] to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$500 / individual or $1,000 / family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care and primary care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. $300 for prescription drug coverage and $300 for occupational therapy services. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	For network providers $2,500 individual / $5,000 family; for out-of-network providers $4,000 individual / $8,000 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Copayments for certain services, premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.[insert].com or call 1-800-[insert] for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.

OMB control number: 0938-1146/Expiration date: 05/31/2026

Page 1 of 5

In-Network Pharmacies

In-network pharmacies are pharmacies that have partnered with your health insurance provider to bring you the maximum amount of benefits. These pharmacies are familiar with your plan and provide medication at no extra charge than what is agreed upon by your insurance plan. If you use a pharmacy outside of your network, you will likely pay extra costs for your medication.

Non-Medical Switching

Non-medical switching is a practice where health insurers require you to switch medications for reasons unrelated to your health, typically to save money on prescription drug costs. Non-medical switching happens on an individual basis, unlike formulary changes that affect anyone with that drug plan.

Non-medical switching can mean your insurance company stops covering a certain medication or places it on a high tier, which we know will cost you more. For some, if this occurs, the drug may become hard to afford and may force you to switch to a less expensive alternative.

There are concerns that non-medical switching can disrupt a stable patient's treatment plan. Switching medications can lead to side effects or reduced effectiveness of treatment.

What you can do: If you have concerns about your treatment being switched, contact your provider to let them know. You can work together to appeal to your insurance company for the original treatment (more on this later).

What if a Medication I Need is Not on My Formulary?

If you need a drug that isn't on your health plan's list, your treating provider can submit a formulary exception request for you. There are several reasons you may want to do this:

- **You might be allergic to the alternative medications your plan covers.**
- **You might have already tried covered alternatives, but they didn't work for you.**
- **The covered alternatives might interact badly with other medications you're taking.**
- **The formulary drugs may cause problems due to other health conditions you have.**
- **If you and your provider believe a brand-new drug is the best option, they can request an exception since it usually takes a while for insurance plans to add newly approved drugs to their formulary.**

There is no guarantee your insurance provider will grant a formulary exception. If not, there's an appeal process. This way, you and your doctor have options to get the medication you might need, even if it's not on the list initially.

What Do I Do if My Medication is Denied?

Finding out that your prescription is not covered by your insurance plan or pharmacy does not mean that you will have to go without it. It means that there might be more paperwork needed to show the medication is necessary for your care.

If your medication is denied, it's important to understand why. Here's what you can do:

FIND OUT THE REASON

- **Ask Your Pharmacist:** Your pharmacist may know why your medication claim is not covered.
- **Call Your Insurance Company:** If your pharmacist doesn't have the information, contact your insurance company directly.

UNDERSTAND THE DENIAL

- The denial reason will help you understand if you need additional information from your doctor or if the prescribed drug is not on your health plan's formulary.

NEXT STEPS

- **Troubleshoot:** Address any issues like missing information or prior authorization.
- **Submit an Appeal:** If your medication is still denied, you can submit an appeal to your insurance company for reconsideration.

WORK WITH YOUR DOCTOR

- Inform your doctor immediately. They can help gather additional documentation and coordinate with your health plan for coverage.
- **Find Alternatives:** While waiting, you and your doctor can explore alternative medications that are covered and suitable for your condition.

COMMON MEDICATION DENIAL REASONS

- The medication requires prior authorization.
- The medication requires step therapy that has not been completed.
- The medication is off-formulary or is excluded according to your health plan's benefits.
- The maximum number of refills (or quantity) has been exceeded for this prescription.
- Your health plan may only cover generic medications.

Review our guide, *Engaging With Insurers: Appealing a Denial* for more information about the appeals process.

https://education.patientadvocate.org/resource/engaging-with-insurers-appealing-a-denial-2/

Prescription Cost Help

Manufacturer's Co-Pay Cards

Medication manufacturers frequently offer discount or coupon cards to eligible patients. These cards can lower your co-pay for your medication to a much more affordable rate, sometimes as low as $5 a month. Double-check with the pharmacist if you and your prescription are eligible for manufacturer's co-pay cards. Co-pay card approval is immediate.

Manufacturer's Low-Cost/ Free Drug Programs

If you are not eligible for a manufacturer's or organization's co-pay assistance program, are uninsured, or your health plan will not cover your medication, you may want to look into a medication program sponsored by the maker of the medication. Many manufacturers offer free drug programs or low-cost options specifically for those without insurance. Many of these programs have applications that require you to verify your income. If approved, the manufacturer will mail the medication to you or your doctor's office for your use.

Co-Pay Assistance Organizations

These programs provide direct financial support to underinsured patients, even if you have government-sponsored insurance like Medicare, Medicaid, or Tricare. These programs require you to complete an application to determine if you medically and financially qualify based on individual program requirements. If approved, the program can help with your out-of-pocket costs including co-pays, co-insurance, and deductibles related to medication expenses. The programs typically have a cap on the grant amount you will receive, which will be communicated to you when you complete the application.

Speak With Your Prescribing Provider About Alternatives

If your health plan will not cover the prescribed medication, talk with your provider about what other options might be available. Another cheaper medication on your plan's formulary may work just as well. Additionally, you may be eligible for clinical trials based on your health condition.

If you would like to learn more about saving money, please check out our Lighthouse Training Series about planning for medical costs.

https://education.patientadvocate.org/resource/a-guide-for-paying-for-medications-tip-sheet/

Co-Pay Accumulators

A co-pay accumulator is a strategy used by some health insurance plans and PBMs to manage prescription drug costs. Here's how it works:

HOW IT AFFECTS YOU

If you use a manufacturer co-pay assistance program (a co-pay card) to help pay for your medication, the amount covered by the co-pay card does not count towards your insurance deductible or out-of-pocket maximum.

EXAMPLE

- Your medication costs $150, and you have a $500 deductible.
- You have a co-pay card that covers $100, so you pay only $50 upfront.
- With a co-pay accumulator, the $100 from the co-pay card doesn't count towards your $500 deductible. You still need to pay the full $150 until you reach your deductible.

IMPACT

- You might have to pay more upfront, which can be a financial burden, especially if you need ongoing medication for a chronic condition.
- This strategy encourages the use of generic or lower-cost alternatives.

Federal regulations now prevent co-pay accumulators from being applied to medications without generic equivalents. This helps ensure access to essential medications.

Co-Pay Maximizers

A co-pay maximizer is another strategy used by insurance plans to manage costs. Here's how it works:

HOW IT AFFECTS YOU

The insurance plan sets your co-pay (the amount you pay upfront) at the highest value the drug manufacturer's co-pay assistance program offers.

EXAMPLE

- Your medication costs $150.
- The manufacturer offers a co-pay card that covers $100.
- With a co-pay maximizer, the insurance plan sets your co-pay at $100, the same amount as the co-pay card, so you pay nothing upfront.
- The plan may set your overall cost-sharing amount for this drug to $100 per month, meaning you'd be responsible for the full $100 every month, even after the co-pay card runs out.

IMPACT

- The money from the co-pay assistance program doesn't count towards your deductible or your yearly out-of-pocket maximum.
- You might end up paying more out of pocket over time.

EQUITABLE ACCESS TO MEDICATION

Everyone should have the opportunity to get the medications they need to manage their health conditions.

Several factors can influence a person's ability to access their prescribed medication. Income and socioeconomic status, race or ethnicity, location, and insurance coverage all play a part in how you access healthcare services and medications. Minority and low-income populations often face greater barriers to accessing essential medications.

While steps are being taken across the country to address these inequalities, equitable access to medication is a complex issue with no easy solutions.

To try and ease these burdens, Patient Advocate Foundation developed Health Equity Funds to get assistance to the people and places who need it the most. We know that a fundamental problem is that not everyone, everywhere has access to the same things in the same way. Where a patient lives plays a major role in determining where and how they receive care and support. The Health Equity Funds provide financial support to eligible patients living in the counties covered by the funds, which is verified using the zip code of the patient's home address.

To learn more about PAF's Health Equity Funds, visit https://copays.org/health-equity/

Patient Advocate Foundation is dedicated to helping individuals with chronic and life-threatening diseases by providing direct patient services to address issues related to accessing care and maintaining financial stability.

To learn more about the Patient Advocate Foundation, please visit www.patientadvocate.org.

paf Patient Advocate Foundation

Patient Advocate Foundation

patientadvocate.org
(800) 532-5274