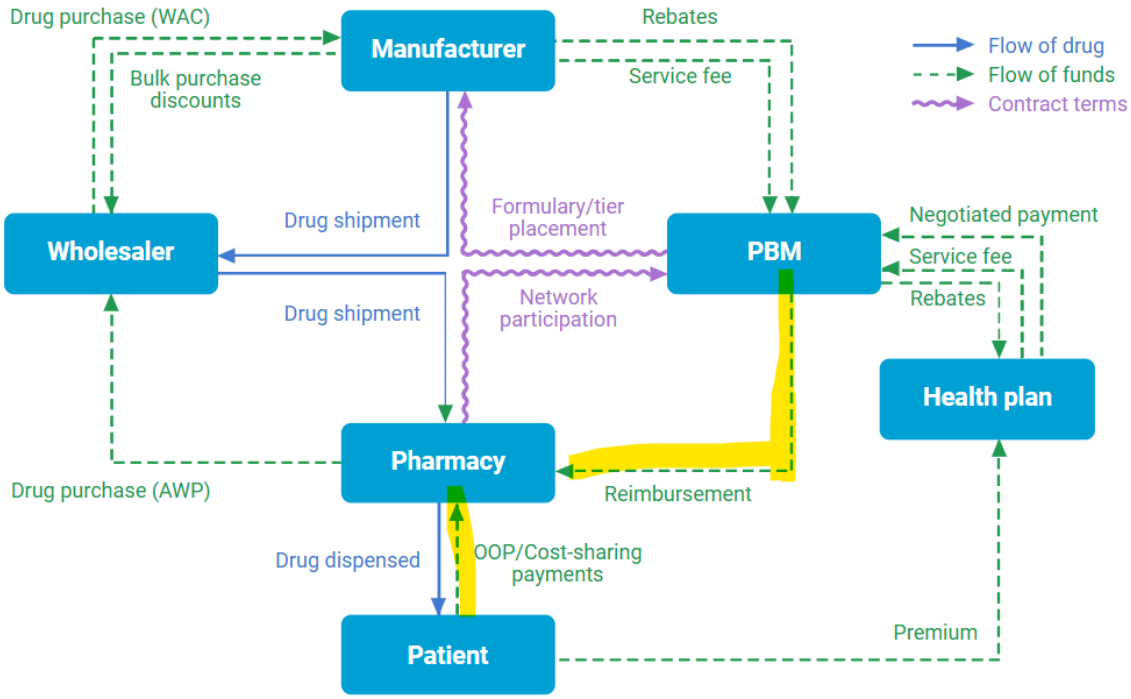
Flow Chart

1. Patient is prescribed Rx by provider.
2. Insurance company approves on-formulary Rx for patient, after prior authorization and other utilization management.
3. Patient pays a copayment (using the financial assistance provided from copayment assistance) to the pharmacy.
    a. Before the deductible is met, patient is paying 100% of Rx cost; after deductible is met patient pays a copayment or coinsurance.
4. Pharmacy submits a claim to the insurer/PBM for the remaining cost of the Rx.
5. The PBM reimburses the pharmacy based on pre-negotiated rate – minus the copayment.
    a. If copayment assistance is counted toward patient's deductible and out-of-pocket limit, eventually the patient's copayment will be reduced and PBM will be reimbursing a larger share (or after out-of-pocket limit is reached,100%) of the Rx cost to the pharmacy.
    b. If copayment assistance is not counted toward the patient's deductible and out-of-pocket limit, the PBM will continue to tell the pharmacy the patient owes a copayment and the PBM only pays (or reimburses the pharmacy) for a portion of the Rx cost.

Flow chart that helps to give a visual of this complicated issue, and shows that the insurer doesn't touch the money, but the PBM they've hired does:



Questions to consider:

1. Insurers/PBMs are claiming that if the copay accumulator goes away, it will raise premiums (which we have data that shows premiums do not increase).
   → How can that be true if the insurer/PBM never sees or touches the copay assistance money?
2. If the insurer can't track the copay assistance, then how do they know not to count the copay assistance toward the deductible and out-of-pocket limit?
3. The insurer/PBM receives discounts, rebates, etc. for the Rx from the manufacturer – none of which is shared with the patient.
   ->The patient pays full price, or a coinsurance based on the full price, of the Rx – more than the PBM paid for it.