RxUtility

THE STATE OF MEDICATION AFFORDABILITY IN 2026 AND PREDICTIONS FOR 2027

THE 3RD ANNUAL RXUTILITY BENCHMARK REPORT

CONTENT

INTRODUCTION:

THE KNOWABLE UNKNOWN PRICE

No healthcare consumer knows what their prescription medicine will cost until they stand at the pharmacy counter.

For three years now, this report has tracked the same questions: What does a prescription cost the consumer out-of-pocket (OOP), what is the lowest price, and can the person paying for it find that price before they pay?

I call this gap "The Knowable Unknown Price." The 2026 reality is that there are many prices the consumer could pay, and the healthcare system knows what they all are. By intention, these prices — and the informed choice transparency would provide — are hidden from consumers.

The prices sit in spreadsheets that are owned by various healthcare stakeholders, resulting in as many as seven consumer OOP prices for any drug on any given day:

Price No. 1: The copay price. The consumer's cost-sharing price if they use insurance and are not in their deductible phase. This price is based on formulary tier (a flat price, like $15 or $25) that increases as the tiers increase.

Price No. 2: The other OOP price. The consumer's cost-sharing price if they use insurance and are in their deductible phase. Consumers are financially harmed here because they pay the full "list price" of the drug when their plan sponsor would pay the "net price" if the employer were paying for it.

Price No. 3: The co-insurance price. The consumer's cost-sharing price for expensive drugs on the higher formulary tiers. This price is a percentage of how much the plan sponsor pays for the drug (typically 20%).

Price No. 4: The manufacturer copay coupon price. The consumer's cost-sharing price when a coupon is used. Most often, the coupon brings the consumer's OOP down to $0-$25.

Price No. 5: The cash discount card price. This is actually a category of prices because there are many, many cash discount cards and pharmacy loyalty programs that offer daily dynamic pricing, which differs at every pharmacy. Think BuzzRx, SingleCare, or GoodRx.

Price No. 6: The direct-to-consumer price. New in 2026, this is the price a consumer pays if they buy a prescription drug directly from a manufacturer's digital storefront. There are currently six manufacturers offering direct-to-consumer (DTC) prices, and the trend will accelerate in 2027.

Price No. 7: The government most-favored price. Listed on the TrumpRx website, these cash (sometimes called self-pay) prices are not, in many cases, unique, alongside some government negotiated prices for certain drug categories, like IVF. The website aggregates and displays the DTC prices and Mark Cuban's Cost Plus Drugs prices.

The spread across these prices is astonishing. There is no mechanism for consumers to see and compare these prices, no "Expedia for drug prices," nor do most Americans even know these prices exist. They wouldn't know to look for them. That is why we do this report every year.

Our capitalistic healthcare system creates incentives that we all behave toward, companies and individuals alike. Drug price transparency threatens each constituent in a different way, but the power of consumerism, plus mounting legislation and regulation, is putting pressure on systemic inertia.

Since 2020, payers have been required to publish their negotiated drug prices. We have found only two payers that have done so — Blue Cross and Blue Shield of Texas and Baylor Scott & White Health Plan. The rest have not yet complied, but they will. Pharmacy benefit managers (PBMs) are now required to provide transparent options that allow 100% rebate pass-through to plan sponsors and consumers. The CMS Health Tech Ecosystem of over 800 companies has pledged to implement price transparency and real-time pharmacy benefit checking that a consumer can use to see the prices. These are all good policy initiatives, but they will continue to be, by nature, slow-moving.

The 2026 fast-moving catalysts in drug price transparency are manufacturer-direct pricing and TrumpRx. Now that consumers can see drug prices and have more than one way to buy, they will demand more transparency and more choice.

That's the real story in this year's data. The prices are still opaque, the spreads are still wide, and coupons are still underused. But for the first time, the fix isn't only in Washington's hands or a PBM's contract terms. It's in a URL. Consumerism forced the industry to get more competitive, and competition is doing work that a decade of transparency mandates cannot.

Looking forward to 2027, I am optimistic that these tailwinds will propel real progress. The pricing data exists, and technology is not a problem. In a transparent environment, capitalism can work in the consumer's favor to make the lowest price the easy price to find.

Let's keep working together to help people afford medicine.

Miriam

Miriam Paramore
CEO and Founder, RxUtility

BREAKDOWNS IN MEDICATION AFFORDABILITY DON'T HAPPEN BY CHANCE

A retired woman with Type 2 diabetes had private health insurance, yet she still paid $200 a month for Rybelsus, a medication prescribed to help manage her blood sugar. It was an expense she could scarcely afford.

A volunteer with the PatientPoint Foundation,* which serves high-risk populations, offered to search for a lower price using an app on her phone. The tool identified several pharmacies where the woman could fill the prescription for $42 — a monthly savings of $158.

"She was in complete shock and awe, and so was her daughter, who was assisting her," the volunteer said. "This is the type of information everyone needs to stay healthy."

Too often, consumers cannot readily access drug prices, even though the data is available and the technology needed to put this information in their hands has existed for years.

For instance, five of the top six immunology drugs could be free to consumers if they were to use a copay coupon, and the sixth would only cost $5. But most patients never find out a copay coupon exists. And even when they do know a copay coupon is available, they struggle to access it.

* The PatientPoint Foundation helps mitigate health disparities by using tools and assets to overcome obstacles to access to care. In this example, an ambassador for the PatientPoint Foundation used a digital tool to help a woman find the lowest price for the medication she needed in August 2026.

The Top 6 Immunology Drugs Cost Most Patients More than They Should

RxUtility examined the top six immunology drugs by revenue and asked a simple question: "If a copay coupon for these drugs exists, how easy would it be for a patient to access this information and find the coupon?"

The potential savings is quantified below by drug. On average, the ability to find the lowest price and access it with a coupon scored at 2.5 on a 5-point scale, indicating breakdowns in passing these savings to consumers, according to an RxUtility analysis.

BRAND NAME	THERAPEUTIC AREA/CLINICAL GROUP	LOWEST COPAY PRICE W/ COUPON	AVG PATIENT OOP PER SCRIPT (COMMERCIAL)	AVG CONSUMER OOP SAVINGS W/ COUPON	ANNUALIZED COMMERCIAL RX VOLUME (BASIS FOR OOP AVG)	COUPON DESCRIPTION
HUMIRA	Dermatology — TNF-alpha inhibitor	$0.00	$496.17	**$496.17**	294,198	*Humira Complete Savings Card: Eligible commercially insured patients may pay as little as $0 per monthly prescription.*
STELARA	Dermatology — Interleukin inhibitor	$5.00	$745.66	**$740.66**	248,278	*Stelara withMe Savings Program: Eligible commercially insured patients may pay $5 per dose.*
DUPIXENT	Dermatology — Agent for dermatitis	$0.00	$393.44	**$393.44**	1,802,362	*Dupixent MyWay Copay Card: Eligible commercially insured patients may pay as little as $0 per prescription. Subject to a maximum annual savings limit.*
RINVOQ	Gastrointestinal — JAK inhibitor	$0.00	$472.36	**$472.36**	604,778	*Rinvoq Complete Savings Card: Eligible commercially insured patients may pay as little as $0 per dose.*
ENTYVIO	Gastrointestinal — Monoclonal antibody	$0.00	$438.05	**$438.05**	10,102	*Entyvio Connect Co-Pay Program: Eligible commercially insured patients may pay as little as $0 per dose.*
SKYRIZI	Dermatology — Interleukin inhibitor	$0.00	$1,280.78	**$1,280.78**	562,860	*Skyrizi Complete Savings Card: Eligible commercially insured patients may pay as little as $0 per dose; annual maximum savings of $14,000 per calendar year.*

The immunology data is an example of the structural breakdowns that hold consumers back from getting the best price for the medications they need. When these breakdowns occur, all key stakeholders — not just the consumer — lose.

The Impact of Medication Affordability Breakdowns Extends Beyond the Consumer

- Cost-related medication non-adherence contributes to more than **$500 billion** in avoidable healthcare costs each year.[1]
- Employers face productivity **losses** and higher rates of absenteeism.[2]
  - Patients with asthma or chronic obstructive pulmonary disease who take their medications as directed take fewer days off from work. The savings: **$2,504 less** per employee per year.
- Health disparities widen, accounting for **$320 billion** in healthcare spending annually — a crisis of unsustainable proportions.[3]

Now, there are signs that the industry is fighting back — through policy change, tech innovation, market innovation and consumer and employer empowerment.

Here are the top systemic failures that are obstructing progress toward medication affordability.

Affordability Obstructor 1: Gaps in drug pricing transparency persist despite laws mandating it. It's been six years since the Transparency in Coverage Final Rule promised consumers a clearer view into healthcare prices, including prescription drug pricing. Yet health plans still won't tell their members how much their medications will cost if they were to use their insurance coverage to pay for them. They must do so by Jan. 1, 2027, to comply with a mandate by the Centers for Medicare & Medicaid Services and the Office of the National Coordinator for Health Information Technology.

Delays in meaningful enforcement of drug price transparency laws aren't just an inconvenience. They're a consumer-rights failure. When patients can compare the price of an airline ticket, a mortgage, or a gallon of gas, but not the out-of-pocket cost for the medications they need, the system is not merely opaque. It's designed to keep consumers guessing. It's time to lift the veil of secrecy around drug prices, including negotiated rates, to give consumers informed choice.

Affordability Obstructor 2: Mechanisms limit the impact of copay assistance programs. Copay coupons lower or eliminate the patient's out-of-pocket cost at the pharmacy. Most copay coupons — 79.5% — are for drugs that have no generic equivalent. But lack of consumer awareness and the difficulty in digitally accessing copay coupons limits their impact.

A KFF analysis found that while copay assistance is available for the vast majority of brand-name prescription drugs, it was applied to just 19% of prescriptions for patients with private insurance in 2023. However, use of copay assistance for certain therapies was much higher. For example, one out of three brand commercial prescriptions for the top 10 therapies prescribed in 2023 were paid for using copay coupons.[4]

Assessing Copay Coupon Assistance Opportunities by Condition

Note: In instances where copay coupons have declined year over year, the decline isn't a sign that manufacturers are broadly pulling back on patient financial assistance. Instead, this is largely a byproduct of the normal drug lifecycle — patents expiring and generics launching — as well as product discontinuations.

CONDITION		2025	2026
DIABETES	# coupon types available	106	34
IMMUNOLOGY	# coupon types available	46	15
CARDIOVASCULAR	# coupon types available	28	60
RESPIRATORY	# coupon types available	45	46
MENTAL HEALTH	# coupon types available	75	65

Source: RxUtility.

At a Glance: The State of the Copay Coupon Market

In 2026, 175 copay coupon programs were discontinued, but 94 new ones were launched. This means that for roughly every one out of three copay programs that ended in 2026, a new program took its place.

Here is a snapshot of year-over-year copay coupon trends:

1.	2.	3.	4.
Medication Copay Assistance Programs 2025: 1,298 2026: 1,217	Retail Drug Copay Assistance Programs 2025: 801 2026: 783	Specialty Drug Copay Coupon Availability 2025: 497 2026: 434	Percentage of Copay Coupons for Medications with No Generic Alternative 2025: 78% 2026: 79.5%

There are also mechanisms at play that seek to blunt impact of copay coupons on medication affordability. One mechanism is the copay accumulator, which prevents manufacturer assistance from counting toward a patient's deductible. Today, 26 states have restricted or banned copay accumulators. However, these bans typically only apply to fully insured plans due to the Employee Retirement Income Security Act (ERISA) loophole; they do not apply to self-funded (ERISA-governed) employer plans, which cover the majority of commercially insured workers. Another is the copay maximizer, which spreads the value of assistance over time so that it reduces immediate cost, but doesn't accelerate progress toward out-of-pocket limits.

These mechanisms are typically embedded in contracts between PBMs and plan sponsors, often self-insured employers seeking to control overall drug spending. At the pharmacy counter, however, the distinction is invisible. A patient uses a coupon, believing they are receiving meaningful relief, only to discover later they are still responsible for the same underlying financial burden.

Affordability Obstructor 3: The technology to support an instant view into prescription affordability hasn't been widely adopted. Software that can surface real-time pricing data at the point of prescribing or dispensing already exists. There are systems that can compare insurance pricing, cash options and available assistance instantly. It is possible to show a patient, clearly and immediately, what their lowest-cost option is and why. Yet most pharmacists typically do not have access to this technology within their workflows, where it can be accessed in real time while the patient is in front of them. Neither do providers. And until they do, medication out-of-pocket costs will remain shrouded in secrecy.

> Yet there are also signs of progress — affordability accelerators — that are making an impact. Some are happening through market innovation and tech innovation; some are happening through consumer empowerment.

Affordability Accelerator 1: Direct-to-consumer pricing drives medication costs down. In the past year, Eliquis's list price hasn't changed, but the new DTC cash price of $346, a 43% discount, has launched alongside it. Cost-conscious consumers, especially in their deductible phase, are taking advantage of a new way to buy. In the past year, RxUtility data reveals the substantial discounts off list prices that can be acquired through DTC pricing options for numerous drugs. Categories for the five drugs reflecting the largest price reductions range from GLP-1s to immunology and heart health drugs.

Top 5 Direct-to-Consumer Price Markdowns in 2026

Manufacturer-to-patient (DTP) programs offering the steepest self-pay cash discount vs. list price, ranked by % discount

RANK	DRUG (GENERIC)	MANUFACTURER	DTP PLATFORM	THERAPEUTIC AREA	LIST PRICE (30-DAY, $)	DTC CASH PRICE ($)	MONTHLY SAVING ($)	% DISCOUNT
1	**Sotyktu (deucravacitinib)**	Bristol Myers Squibb	BMS Patient Connect	Immunology (plaque psoriasis)	$6,868	$950	$5,918	**86%**
2	**Wegovy (semaglutide) oral tablet**	Novo Nordisk	NovoCare Pharmacy	Obesity / Diabetes	$1,349	$149	$1,200	**89%**
3	**Zepbound (tirzepatide)**	Eli Lilly	LillyDirect	Obesity	$1,086	$299	$787	**72%**
4	**Cosentyx (secukinumab)**	Novartis	Novartis Direct-to-Patient Platform	Immunology (psoriasis, PsA, HS)	$7,936	$3,571	$4,365	**55%**
5	**Eliquis (apixaban)**	Bristol Myers Squibb / Pfizer Alliance	Eliquis 360 Support (via BMS Patient Connect)	Cardiovascular (anticoagulant)	$606	$346	$260	**43%**

Source: RxUtility proprietary data.

Affordability Accelerator 2: Off-benefit pricing expands access to lower prescription costs. Off-benefit pricing lets consumers bypass insurance and pay a discounted cash price for prescriptions. Consumer demand for GLPs has come into conflict with the lack of insurance cover. This standoff has fueled a new market of direct-to-consumer from compounding pharmacies. Manufacturers entered the D2C market by competitive necessity. This prices trend gives consumers better line of sight into how much their prescription medications cost across a variety of channels: with insurance or without; with a copay coupon or through a cash-pay discount program; through a subscription service or by mail order from another country.

Affordability Accelerator 3: Healthcare and key stakeholders are ready for an affordability infrastructure fix. AI won't fix drug affordability, but AI-enabled infrastructure might. While much of the healthcare industry talks about AI in sweeping terms, the more urgent opportunity is practical: using modern data, APIs, and real-time decision support to show consumers what their medications will actually cost and where they can access the most affordable option. This type of technology is available now, and when it becomes widely adopted, it will turn prescription cost intelligence into a powerful lever for medication affordability.

Legislation is moving forward to help create more affordable access to prescription medication. A number of state and federal initiatives seek to make life-saving prescription medications more affordable for patients. There is also important data interoperability standards work and data blocking work being led by the CMS Health Tech Ecosystem, the standards body the National Council of Prescription Drug Programs (NCPDP) and the Carin Alliance. The following table highlights most of the relevant policy initiatives.

Relevant Legislation & Regulation — Federal and State

LEVEL	LAW / RULE	STATUS (AS OF SEPT. 6, 2026)	RELEVANCE	CITATION
Federal	Consolidated Appropriations Act, 2026 (Pub. L. 119-75, H.R. 7148)	Signed Feb 3, 2026. PBM transparency reforms: 100% rebate pass-through to ERISA plans, mandatory semiannual pricing/rebate reporting. Effective plan years on/after Aug 3, 2028 (Jan 1, 2029 for calendar-year plans).	Direct pillar-2 (TiC non-compliance) and pillar-4 evidence for "won't, not can't" — law passed, enforcement gap of 2+ years.	*congress.gov/bill/119th-congress/house-bill/7148/text*
Federal	HELP Copays Act (H.R. 6423)	Reintroduced in House before Dec 2025 recess; not yet passed as of Sept 2026.	Directly addresses copay accumulator/maximizer enforcement gap; cited by Carl Schmid (Contagion Live) as the federal fix.	*hemob.org/resource-library/01-13-2026*
Federal	D.C. Circuit ruling striking down 2020 HHS rule permitting copay accumulators	Ruling in effect (2023); "the federal government has given no signal that it is prepared to enforce the ruling."	Core evidence for the enforcement-gap argument — a legal win with no enforcement mechanism.	*the-rheumatologist.org/article/state-copay-accumulator-legislation-an-overview*
Federal	CMS Final Rule, ACA Marketplace plans — copay assistance counts toward OOP max	Effective plan year 2027; applies only to ACA marketplace plans, not employer-sponsored coverage.	Narrow win — doesn't touch the 65% of covered workers in self-funded ERISA plans.	*careroute.ai/blog/copay-accumulator-trap*
Federal	CMS RTBT/RTBC mandate (42 CFR 423.160(b)(7)), NCPDP RTPB Standard v13	Prescriber RTBT required since Jan 2021; beneficiary RTBT since Jan 2023; NCPDP standard version upgrade required by Jan 1, 2027.	Direct pillar-4 (real-time benefit check non-implementation at consumer-facing level) — mandate exists but doesn't require prescriber use, and the standardized version isn't required until 2027.	*ankura.com/insights/new-health-information-technology-standards-for-medicare-part-d; cms.gov*
Federal	Most-Favored-Nation (MFN) Executive Order, "Delivering Most-Favored-Nation Prescription Drug Pricing to American Patients"	Signed May 12, 2025. 26 manufacturer agreements as of Aug 2026 (89% of branded market). TrumpRx.gov launched Feb 5, 2026.	Direct tie to Eliquis DTC pricing and TrumpRx channel; reporting shows U.S. consumers still pay far more than international MFN comparators despite deals.	*whitehouse.gov fact sheets (May 2025, Aug 2026); time.com, Sept 1 2026*
Federal	CMS GLOBE and GUARD Models (proposed MFN payment models, Part B/Part D)	Proposed rules; comment period closed Feb 23, 2026; GLOBE targeted effective date Oct 1, 2026; not yet finalized.	Emerging — could reshape how MFN pricing flows through Medicare specifically.	*sidley.com, April 2026*
Federal	Inflation Reduction Act — Medicare Drug Price Negotiation Program	Ongoing; Eliquis among first negotiated drugs, $231/month effective Jan 2026.	Directly ties to the Eliquis example — negotiated price is lower than the DTC "discount" price.	*kff.org; congress.gov/crs-product/LSB11319*
State (aggregate)	Copay accumulator bans	26 states + D.C. + Puerto Rico as of Jan 2026 (New Jersey most recent); 14 states have pending legislation.	Core pillar-2 evidence; note ERISA preemption limits these bans to fully insured plans only.	*hemob.org, Jan 13 2026; careroute.ai*
State	Nevada Division of Insurance 2025 Health Benefit Plan Filing Guidance	Nevada elected to enforce the D.C. Circuit ruling directly starting 2025 — the only state doing so via regulatory guidance rather than legislation.	Useful contrast case: one state enforcing what the federal government won't.	*the-rheumatologist.org*
Structural	ERISA preemption	Ongoing — state accumulator bans do not apply to self-funded employer plans (65% of employer-covered workers).	Explains why state-level wins understate the scope of the problem — a structural reason "won't, not can't" persists even where states have acted.	*careroute.ai/blog/copay-accumulator-trap*

2027 LANDSCAPE

3 Predictions Shaping Medication Pricing and Access in 2027

1. **We will see a rise in the use of off-benefit pricing for prescription drugs.**
   Off-benefit pricing allows consumers to bypass their health insurance and pay a discounted cash price for a prescription. Today, rising interest in this option has led to an entirely new market for direct-to-consumer prescription discount services.[5] Key players range from prescription discount services like GoodRx, SingleCare and WellRx to companies that sell GLP-1s directly to consumers without requiring insurance. We're already seeing manufacturers sell non-GLP drugs like Eliquis, a blood thinner, directly to consumers at greater than a 40% discount.[6]

The implications: One implication of this trend is that consumers will have a better line of sight into how much their prescription medications cost across a variety of channels: with insurance or without; with a copay coupon or through a cash-pay discount program; through a subscription service or by mail order from another country.

The risks:

- Without visibility into the medications patients are taking, providers lose the ability to monitor medication adherence or manage utilization.
- Medication non-adherence not only leads to poor health outcomes, but also raises healthcare costs — to the tune of $500 billion in avoidable healthcare costs per year.[7]
- In the U.S., where 58% of patients stop taking their prescriptions prematurely, the risk of medication non-adherence for patients who relied on off-benefit pricing for medication access but couldn't keep up with the cost is of particular concern.

The recommendation: Industry stakeholders must agree to new information flows that can track, report, and reconcile the purchase of medications on- and off-benefit. The Carin Alliance, NCPDP, and the Health Tech Ecosystem are key conveners in this work that will require some level of federal and perhaps state funding.

2. **Direct-to-patient prescription programs will prompt employers to look at new options for coverage.** The GLP-1 boom opened options for medication access that had never existed. Today, options for GLP-1s range from direct-to-patient (DTP) models to direct-to-employer (DTE) models that help companies bypass traditional pharmacy benefit managers to reduce the cost of weight-loss medications. Some DTE models tie services such as nutritional counseling nurse check-ins to prescription access — and that's creating a brand-new benefit model for these drugs.

The implications: We predict the popularity of DTP and DTE for GLP-1s will spill over to triple-agonist weight-loss drugs — often called GLP-3s — for use for musculoskeletal health. Currently, these drugs are being prescribed off-label by physical therapists. It will also likely lead to a wave of prescription medications that are paid for off-benefit.

The risks:

- With so much being prescribed outside of the provider's view, this raises questions around who owns the conversation around medication adherence.
- Employers may still struggle to manage GLP-1 benefit costs, even under these new models, due to intense consumer demand.
- Diminished insight into medication use by patients puts both payers' and providers' performance under value-based payment models in jeopardy.

The recommendation: Employers must insist on comprehensive pharmacy-related tech and workflows. Employers hold tremendous power to push for a solution at the industry and policy levels. They need flexibility to support consumer choice across prescription fulfillment pathways and they need to be able to follow the money and track outcomes. Employer purchasing power will reward health plans and PBMs that can provide a contemporary, not a dated, view of the current multi-channel, off-benefit options.

3. **Pharmacy benefit management (PBM) reform has reached a historic policy breakthrough, but the real test will be implementation and accountability.** PBM reform is the most consequential structural change the drug-pricing industry has seen. Requiring consumers — especially those who have not yet met their deductible — to pay for their medications based on the negotiated net price rather than the inflated list price could substantially reduce out-of-pocket harm. But passage of the Consolidated Appropriations Act of 2026, which calls for increased transparency and reshapes how PBMs are paid, is not the finish line. Transparency remains poor, and accountability will determine whether reform produces meaningful affordability instead of new versions of the same old pricing games.

Implications: Consumers still generally cannot see the out-of-pocket price they will pay for a prescription drug when using insurance before they reach the pharmacy. Moreover, payers have failed to comply with existing transparency requirements, choosing instead to pay fines for non-compliance, a failure that has received too little attention.

The risks:

- PBM practices could continue to undermine affordability. Copay accumulator and maximizer programs remain examples of games that can expose patients to unexpected costs.
- The industry cannot avoid the new law, but it may relabel the money. Pharmaceutical manufacturers, PBMs and plan sponsors may shift rebate dollars around or rename them rather than fundamentally surrender revenue. In addition, the law only requires PBMs to make pass-through options available to employers. Employers can still choose the old rebate models when negotiating plan design.
- Consumerism is moving faster than the insured market. Cash pricing, DTP and DTE programs and other off-benefit options are creating more competition and lower prices in some instances. However, they are also fueling more fragmentation and less visibility for employers and health plans. This threatens their ability to meet members' needs in cost-effective ways.

The recommendation: Use price transparency as a lever to improve overall visibility into medication affordability and access, despite implementation of legal or regulatory reforms. The data and technology exist to surface all price points to employers and consumers, creating a data-rich playing field that makes it possible to calculate employer and consumer cost-sharing with confidence. Enforcement of existing transparency laws is required, as is the adoption of the consumer-facing real-time pharmacy benefits transaction in an app-agnostic way.

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