EDITORIAL AND COMMENT

# Reducing Out-of-Pocket Costs to Coordinate Prescription Medication Benefit Design with Chronic Disease Outreach and Clinical Care

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Increases in patient out-of-pocket costs are a clear barrier to the use of and adherence to effective chronic condition medications, especially for high-risk patient groups.[1, 2] It is less clear, however, whether and how well implementing programs that selectively reduce patient out-of-pocket costs for specific chronic disease medications can help engage patients, increase medication adherence, improve chronic conditions management, and reduce negative health outcomes.

In this issue of JGIM, Trivedi et al. report on a natural experiment of a medication copayment reduction program implemented for indigenous Australian patients with, or at risk for, a chronic disease.[3] The copayment reduction was part of a multi-dimensional policy change that introduced a package of chronic disease-related programs linking outpatient medical care and outreach programs to support self-management. This study is unique in targeting cost relief toward a patient population with a history of disparities in the treatment and outcomes of chronic conditions. The authors find that the chronic disease programs were associated with declines in hospitalizations for chronic conditions among indigenous Australians living in geographic areas with high uptake of the program, which led to a narrowing of the gap in hospitalization rates between the eligible indigenous and ineligible non-indigenous populations.

## EXPERIENCES WITH COPAYMENT REDUCTIONS FROM OTHER SETTINGS

Other benefit designs that incorporate copayment reductions for high-value services and medications include US value-based insurance design (VBID) provisions in both public and private health insurance coverage. These VBID benefits are designed to scale patient out-of-pocket costs according to the clinical value of the health care services received. Instead of acting as a blunt instrument, nuanced cost-sharing plans can selectively reduce patient out-of-pocket cost for high-value health care services such as chronic disease care. For example, in US employer-sponsored VBID plans, some purchasers have waived copayments for chronic condition medications and have generated modest improvements in medication adherence behavior, including findings suggestive of improvement in health events.[4]

Further, US health reform requires that copayments be waived specifically for high-value preventive services even when out-of-pocket costs for other health care services remain high.[5] Medication copayments are also limited for lower-income populations through Medicaid and cost-sharing subsidies tied to income under provisions of the Affordable Care Act. Programs have been specifically designed to reach vulnerable patient groups with a history of health disparities, such as through the Indian Health Service in the US.[6] In addition, medication assistance programs implemented by pharmaceutical companies or foundations have offered reduced-cost medications to patients, although these programs may also have a broader impact by increasing drug costs.[7]

The impact of any particular benefit plan likely varies across patient populations and settings, and according to plan details. As health care settings worldwide implement and explore various strategies for selectively reducing out-of-pocket costs for high-value health care services or among specifically vulnerable populations, more research is needed to build evidence of the impact of nuanced programs in order to inform further implementation.

## COPAYMENT REDUCTIONS COMPLEMENT CHRONIC CONDITIONS MANAGEMENT STRATEGIES

Beyond reducing copayments, the suite of programs in the Indigenous Chronic Disease Package offered a comprehensive approach to supporting patient engagement in chronic conditions care. The program relied on a suite of evidence-based practices to improve chronic disease outcomes,[8] including financial incentives to primary care providers for identifying and enrolling eligible patients in the program, increased access to chronic conditions care management by nurses and other health professionals, enhanced access to specialists, and increased patient self-management training from community health workers. The intervention was broadly designed to close chronic condition health care gaps in addition to

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copayment gaps. Together, these program components include clear pathways for improving primary care and outpatient health care use, increasing patient engagement, and improving patient self-care behaviors.

Although the many components of the support program limit our ability to attribute declines in hospitalizations solely to the reduction in out-of-pocket medication costs, the programs likely acted in complementary ways to produce the observed improvement in outcomes. Additional program commitment to creating a population data-monitoring system also likely informed health care providers of gaps in care and opportunities for further outreach. Further, the medication cost reductions could also have contributed to shifting patient care-seeking behavior and thereby indirectly improve primary care use, since patients may be more likely to visit their provider if they anticipate that they can also afford the treatment prescribed.

Too often, decisions about benefit designs and out-of-pocket costs, whether increases or decreases, are disjointed from clinician-driven initiatives and outreach aimed at delivering high-quality clinical care. This fragmentation can result in high patient out-of-pocket costs that present a barrier to patient access for the very same services that quality improvement efforts seek to deliver. To the degree that benefit designs are thoughtfully designed and sufficiently nuanced so as to complement chronic disease programs, the two can work together toward improving chronic disease outcomes and reducing health disparities in vulnerable populations.

Of course, the impact of any copayment reduction program is dependent on patient engagement and awareness of the benefits and services available. Previous research has consistently found that patients have limited awareness of their benefit design details, including often being unaware of free preventive care.[9] Although the rate of participation in the indigenous Australian copayment incentive program was modest, educational efforts by general practitioners may have supported patient engagement.

Still, as health care costs grow,[10] including medication costs in particular, efforts to reduce the barrier that out-of-pocket costs pose to high-quality care for chronic conditions will likely increase in importance. Further, the value of these efforts is magnified in patient groups with a history of health disparities which may be exacerbated by cost-related barriers to health care access. While benefit designs are an important lever, any change in medication out-of-pocket costs likely addresses only a subset of baseline health care access barriers (those linked directly to out-of-pocket costs). Therefore, the comprehensive approach from this Australian program serves as a strong example of the coordination of copayment reductions and clinical programs in order to improve engagement of vulnerable patient populations, increase access to high-quality chronic disease care, and reduce downstream events.

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***Compliance with Ethical Standards:***

***Conflict of Interest:*** *The author declares that he/she does not have a conflict of interest.*

## REFERENCES

1. **Chernew M, Gibson TB, Yu-Isenberg K, Sokol MC, Rosen AB, Fendrick AM.** Effects of increased patient cost-sharing on socioeconomic disparities in health care. J Gen Intern Med. 2009;23(8):1131–6.
2. **Collins SR, Rasmussen PW, Doty MM, Beutel S.** Too high a price: out-of-pocket health care costs in the United States. Findings from the Commonwealth Fund Health Care Affordability Tracking Survey. September-October 2014. Issue Brief (Commonw Fund). 2014;29:1–11.
3. **Trivedi AN, Baile R, Baile J, Bronw A, Kelaher M.** Hospitalizations for Chronic Conditions among Indigenous Australians after Medication Copayment Reductions: the Closing the Gap Copayment Incentive. J Gen Intern Med. 2016. doi:10.1007/s11606-016-3912-y.
4. **Choudhry NK, Fischer MA, Smith BF, et al.** Five features of value-based insurance design plans were associated with higher rates of medication adherence. Health Aff (Millwood). 2014;33(3):493–501.
5. Kaiser Family Foundation. Fact Sheet: Preventive Services Covered by Private Health Plans under the Affordable Care act. 2015. Accessed 11/29/2016: http://kff.org/health-reform/fact-sheet/preventive-services-covered-by-private-health-plans/
6. Indian Health Service Fact Sheet: Indian Health Disparities. Accessed 11/29/2016: https://www.ihs.gov/newsroom/factsheets/disparities/
7. **Howard DH.** Drug companies' patient-assistance programs – helping patients or profits? N Engl J Med. 2014;37(2):97–9.
8. **Bodenheimer T, Wagner EH, Grumbach K**. Improving primary care for patients with chronic illness. JAMA. 2002;288(14):1775–9.
9. **Reed M, Fung V, Price M, et al.** High-deductible health insurance plans: efforts to sharpen a blunt instrument. Health Aff (Millwood). 2009;28(4):1145–54.
10. **Keehan SP, Poisal JA, Cuckler GA, Sisko AM, Smith SD, Madison AJ, Stone DA, Wolfe CJ, Lizonitz JM.** National health expenditure projections, 2015–2025: economy, prices, and aging expected to shape spending and enrollment. Health Aff (Millwood). 2016;35(8):1522–31.