In 2020, patients in the US spent nearly $389 billion on out-of-pocket medical expenses, including nearly $45 billion on prescription drugs. Patients with higher out-of-pocket costs are less likely to fill prescriptions and take them as prescribed, which can have negative consequences for their health. For patients with chronic conditions who often need to fill multiple prescriptions per month, out-of-pocket costs can be very high, even for those with health insurance coverage. The combination of high prescription drug prices and insurance benefit designs that place more cost-sharing burden on patients can limit access to high-value therapy and is a substantial barrier to achieving pharmacoequity in the US. While the recent passage of the Inflation Reduction Act of 2022, and its provisions such as capping of out-of-pocket costs and the ability to negotiate pharmaceutical prices for Medicare Part D beneficiaries, is an important step forward, more substantive reforms in cost sharing are needed to maximize the value of care.

In theory, cost sharing for prescription drugs is designed to limit moral hazard. In this context, moral hazard is the phenomenon where individuals with low out-of-pocket costs for their medications may use more medications (or more expensive medications) than necessary. Yet high out-of-pocket costs for medications may increase long-term health care spending if an individual’s health is compromised due to an inability to afford medications. Cost-sharing reform is necessary for chronic disease therapies, and we present a complementary set of policy approaches that can improve patient outcomes, promote health equity, and minimize long-term health care expenditures.

Some forms of moral hazard are unlikely for patients with chronic conditions. For example, a patient with atrial fibrillation prescribed an oral anticoagulant medication to prevent stroke is not likely to actively seek additional anticoagulation. Adherence to anticoagulant medications is already complicated by concerning adverse effects and treatment dose changes; cost sharing for these medications simply adds a compounding economic barrier. Similarly, patients with diabetes, heart failure, hypertension, or chronic lower respiratory disease are unlikely to seek additional pharmacotherapy beyond what is necessary to prevent progression of their chronic condition. Real-world evidence demonstrates that adherence to effective, evidence-based, and guideline-directed therapies naturally increases drug costs but can be offset by lower health care costs from downstream medical care. Meanwhile, empirical evidence suggests that increasing cost sharing reduces persistent medication use and adherence, while increasing use of substitute health care services and mortality. Nonetheless, for some conditions such as oncology, newly approved drugs are not proven to be cost-effective and thus caution must be taken when considering cancer therapies as ideal targets for value-based cost-sharing reform.

The current cost-sharing system also directly propagates health inequity. Theoretical evidence from health care economics suggests that cost-sharing schemes ought to be scaled in proportion to disposable income to maximize their effect. When cost sharing is equal for all patients, less wealthy patients are dramatically incentivized to decrease use, while there may be negligible impact on wealthy patients. These incentives have real-world consequences for patients with low income, who are more likely to experience undertreatment of chronic conditions due to medication unaffordability and accordingly experience devastating long-term effects. The financial burden imposed by high cost sharing may also present barriers to obtaining necessary prescriptions in the first place. For example, patients with deductibles or higher copays and coinsurance—including for
primary or specialty care services—may not be able to obtain new prescriptions or renewals of existing prescriptions. Additionally, patients with low income or racial and ethnic minority groups may experience logistical or physical barriers to access to health care professionals and pharmacies. They may also experience differential prescribing patterns even when able to access care, due to implicit or explicit bias. Combined, these barriers create and propagate health inequities.

Patients with multiple chronic conditions also face high accumulated out-of-pocket costs. For example, a patient with diabetes, heart failure, hyperlipidemia, and hypertension could pay hundreds of dollars out of pocket for their medications each month. As a result, many are forced to make difficult choices about what, if any, prescriptions to fill, potentially compromising their long-term health outcomes. Regrettably, individuals and populations who have been historically marginalized are both at higher risk for multimorbidity due to insufficient access to preventive care and treatment and are likely less able to afford greater out-of-pocket costs associated with treatment for multimorbidity, thereby widening health inequities.

Pharmacoequity and high-value care can be improved and long-term medical costs reduced by substantive cost-sharing reform. We suggest 3 concrete policy steps to achieve this goal. First, the Medicare Advantage Value-Based Insurance Design (VBID) model, which allows Medicare Advantage plans to participate in interventions designed to improve value, should be expanded to include cost-effective medications used to treat chronic conditions and to include fee-for-service Medicare beneficiaries. Use of the VBID model should also be encouraged for commercial insurers, where uptake is currently highest. The VBID model has long been used by commercial insurers, and the Patient Protection and Affordable Care Act required Health Insurance Marketplace plans to cover high-value preventive services without a copayment. Currently, the Center for Medicare and Medicaid Innovation VBID model enrolls 7.8 million individuals and includes options to reduce cost sharing for covered Medicare Part D drugs; however, only 76% of Medicare Advantage plans participating in the VBID model offer any such benefit. This model has been limited to subsets of the population or to generic drugs, suggesting considerable room for expansion to include more beneficiaries and a broader range of guideline-recommended medical care (eg, branded medications for which there is not a generic alternative).

Second, value-based payment contracts should be designed to limit out-of-pocket costs for cost-effective preventive medications, and public payers (such as Medicare and Medicaid) should be allowed to negotiate prices for pharmaceuticals. For example, accountable care organization payment models in Medicare should directly incentivize adherence to medications for chronic diseases, perhaps by providing cost offsets to contracting organizations in exchange for waiving beneficiary cost sharing. Furthermore, process measures to incentivize guideline-indicated prescriptions should be implemented. For example, quality metrics that provide reimbursement incentives for appropriately prescribing guideline-indicated medications could help ensure that receiving a prescription is not the rate-limiting step in patient medication use.

Finally, payers should consider options to use reference pricing for pharmaceuticals, wherein the least expensive medication among a set of treatment alternatives is offered at no cost to patients and more expensive options have somewhat higher cost sharing. For example, a reference pharmaceutical pricing strategy might set the copayment for generic metformin to $0, and cost sharing would increase for branded versions of the medication. Reference pricing for pharmaceuticals could promote equity of access to medications while limiting the moral hazard associated with the use of more expensive branded medications.

Effective chronic disease management is critical to improving the health of millions of adults in the US. Deeper investment in prevention is a key step to improving health outcomes, limiting long-term health care expenditures, and promoting high-value care. With bold policy changes, including in cost-sharing reform, the US health system can successfully achieve these goals and improve the overall health of the nation.
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Cost-Sharing Reform for Improved Health Care Equity and Value in Chronic Disease Treatments

ARTICLE INFORMATION
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