The New York Times

When a Co-Pay Gets in the Way of Health

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August 2013

ECONOMISTS specialize in pointing out unpleasant trade-offs — a skill that is on full display in the health care debate.

We want patients to receive the best care available. We also want consumers to pay less. And we don't want to bankrupt the government or private insurers. Something must give.

The debate centers on how to make these trade-offs, and who gets to make them. The stakes are high, and the choices are at times unseemly. No matter how necessary, putting human suffering into dollars and cents is not attractive work. It's no surprise, then, that the conversation is so heated.

What is a surprise is that amid these complex issues, one policy sidesteps these trade-offs. A few drugs — such as beta-blockers, statins and glycogen control medications — have proved very effective at managing hypertension, heart disease, diabetes and strokes. Most insurance plans charge something for them. Why not make drugs like these free? Not for everyone, but just the groups for whom they are provably effective.

In traditional economics, such a policy creates waste. The basic principle is moral hazard: consumers overuse goods that are subsidized. This is why people fly in business class when they're on an expense account but in economy when it's on their own dime.

In health care, a doctor or patient might order an extra test casually, just because it's free. This is inefficiency at its worst: from money spent on costly procedures to tests and medicines that provide little medical benefit, some actions are undertaken only because someone else picks up the check. To discourage this waste, insurance plans charge co-payments. The logic is simple: if patients face costs, they will think more carefully about the benefits.

But people don't always follow a cost-benefit logic. Consider a patient recovering from a heart attack. A small cocktail of drugs may cost a trivial amount — say, $5 — yet it reduces the risk of subsequent heart disease mortality by as much as 80 percent. That's a good deal, but as many as 50 percent of people fail to take these medications regularly.

The problem is basic human psychology. Heart disease is silent, with few noticeable symptoms. You feel fine most of the time, so it's all too easy to justify skipping the statin.

The problem here is the exact opposite of moral hazard. People are not overusing ineffective drugs; they are underusing highly effective ones. This is a quandary that two colleagues —

Katherine Baicker, a professor of health economics at Harvard, and Josh Schwartzstein, a professor of economics at Dartmouth — and I call “behavioral hazard.”

We’ve found that co-payments do not resolve behavioral hazard. They make it worse. They reduce the use of a drug that is already underused.

A recent experiment by a team led by Niteesh Choudhry, a professor of medicine at Harvard, quantifies the problem. The experiment involved nearly 6,000 patients who had just suffered a heart attack, and were prescribed drugs known to reduce the chance of another one — statins, beta-blockers, angiotensin-converting-enzyme inhibitors or angiotensin-receptor blockers. Half had their co-pays for these drugs waived; the other half paid the usual fee.

As expected, more people in the zero co-pay group took the drugs, and their health improved. Those in the zero co-pay group were 31 percent less likely to have a stroke, 11 percent less likely to have another major “vascular episode” and 16 percent less likely to have a myocardial infarction or unstable angina. None of these benefits came at a net monetary cost. The insurers did not spend more in total. By some measures, they spent less.

Behavioral hazard affects all of the drugs listed above. They are all highly effective, and yet adherence to taking them is a problem. This is a major financial issue. The New England Healthcare Institute has estimated that solving non-adherence could save $290 billion a year, or 13 percent of total annual medical spending in the United States. A number this large is surely open to quibbling, but divide it by 10 and it is still a large figure.

I’m not proposing to make all health care free, or arguing for a return to so-called Cadillac health plans. Moral hazard is all too real for many treatments, and in some cases, behavioral hazard reinforces it. Just as people underrespond to inconspicuous symptoms, they can also overrespond to highly noticeable ones. People may seek too much care for back pain, for example, resorting to ineffective or possibly even harmful treatments. Behavioral hazard suggests that we need even larger co-payments for these overused drugs.

My proposal is targeted: Take drugs that are shown to be of very high benefit to some people, and make those drugs free for them.

It’s a simple policy change, and it isn’t meant as a complete solution.

First, researchers like A. Mark Fendrick, a professor of internal medicine at the University of Michigan, and Michael Chernew, now a professor of health care policy at Harvard, argue eloquently for what they call “value based” health insurance. All co-pays should depend on measured medical value; high co-pays should be reserved for drugs and medical services that have little proven value.

Second, some people will neglect to take their medications even if co-pays are zero. This proved true even in the Choudhry study.

Fully solving this problem requires more creativity. GlowCaps, for example, are high-tech tops for pill bottles. They beep and text you if you forget to take your medication. In another approach, Kevin Volpp, a professor of medicine and health care management at the University of Pennsylvania, and his colleagues use lotteries, giving people a chance to win only if they take their medications.

FINALLY, some will suggest that focusing on drug adherence is like closing the barn door. Why not focus instead on the behaviors — eating unhealthy foods or shunning exercise — that created the conditions we must now treat with drugs?

Each of these points has some merit. But they fail the “perfect as the enemy of the good” test. Sure, we should do more. But meanwhile, why continue to charge the same co-pay for statins and beta-blockers as we do for Viagra? At the very least, we need to experiment more with this policy.

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