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From Health Affairs

New Research Finds Patients More Likely To Adhere To Medications When Cost Sharing Is Reduced Or Eliminated

Studies in November Issue of Health Affairs Show Promise of Value-Based Insurance Design as Well as Limits for Reducing Costs or Improving Health

Bethesda, MD -- Having insurance coverage that requires consumers to pay less out of pocket for certain medications--for example, those they must take regularly to combat chronic illness--makes it more likely that they will adhere to their medication regimens. But the jury is still out on whether this strategy will dramatically reduce the rate of growth in health spending, or keep people healthier, according to the November issue of the journal *Health Affairs*.

Two studies in this month's issue examine the effects of value-based insurance design, which as currently construed, typically reduces cost sharing for services that have strong evidence of clinical benefit. The studies show the effect of reducing or eliminating cost sharing on patient adherence to medications.

The studies are part of a thematic cluster of articles that focus on value-based insurance design. The cluster, which was published with support from the California HealthCare Foundation, advances evidence that value-based insurance design is a promising strategy for changing patient behavior but one that needs to be applied and tested more widely.

One study, led by **Harvard Medical School's Nitesh Choudhry**, examined **Pitney Bowes' efforts to get employees to stay on certain high-value medications**. When the self-insured corporation eliminated copayments for cholesterol-lowering statins, employee adherence to the drugs increased 2.8 percent. When the company's policy reduced copayments for the blood clot inhibitor clopidogrel, adherence climbed 4 percent.

A second study examining Blue Cross Blue Shield of North Carolina's broad efforts to eliminate or reduce copayments for medications produced similar results. [Matthew Maciejewski](#), of the **Center for Health Services Research in Primary Care at the Durham Veterans Affairs Medical Center and Duke University Medical Center in North Carolina**, and colleagues found that adherence to prescriptions for plan enrollees with diabetes, hypertension, hyperlipidemia, and congestive heart failure increased between 1.5 percent and 3.8 percent when patients paid less than employees who weren't offered the option.

"If these promising early results are validated in other settings, the trend of rising copayments may be replaced with a long-term trend of decreasing or vanishing copayments," say Maciejewski and co-authors. Others studies that discuss value-based insurance design include:

A second paper by [Choudhry and colleagues Meredith Rosenthal from Harvard and Arnold Milstein from Stanford](#) demonstrates that a growing number of payers are embracing value-based insurance design. They cite the Mercer National Survey of Employer-Sponsored Health Plans, which shows that 81 percent of large employers plan to offer this benefit strategy in the near future. Still, they warn that the ability of benefit design changes to influence patient behavior should not be overestimated. Most of the evidence is tied to use of prescription drugs "leaving many central questions unanswered," they say, including whether this strategy yields better health outcomes or reductions in cost.

For value-based insurance design to have significant impact, payers should be using it with surgical procedures, office-administered and self-administered specialty drugs, implantable medical devices, and advanced imaging services, **says University of California, Berkeley's [James Robinson](#)**. Robinson, a Kaiser Permanente Professor of Health Economics, calls these more expensive procedures "the new frontier for insurance design." Value-based insurance design has proved it works by protecting the most valuable clinical services from consumer cost sharing but Robinson says it's time to affect the major drivers of health care costs that put the most burden on patients.

Three key architects of value-based insurance design, **[A. Mark Fendrick](#), and colleagues [Dean Smith](#) and [Michael Chernew](#)**, call for design to be extended to include higher cost sharing for low-value treatments that are less effective compared with others of comparable costs. They say that a benefit design that couples cost-sharing reductions for high-value services with cost-sharing increases for services not identified as high value could both improve quality and control spending. Although most value-based insurance design programs to date have not targeted low-value services or limited their use, Fendrick and colleagues say this can be done effectively as long as transparent processes are in place to define what constitutes a low-value service. There must also be rigorous efforts to identify those services that produce harm or minimal benefit, and the information resulting from those efforts must be made widely available.

[Marjorie Ginsburg](#) says the public may be more ready than payers think to accept value-based insurance designs that would discourage use of medical interventions that are only marginally useful and very costly. **Ginsburg, executive director of the California-based Center for Healthcare Decisions**, says projects conducted by her organization over the years reveal important lessons for value-based insurance designers. "If employers and health plans are seriously interested in applying the "stick" approach to their health coverage, they have much to gain by involving their employees in designing their value-based insurance program," she says. Ginsburg says it's important to involve employees in coverage design and include such strategies as making enrollment in value-based insurance design programs voluntary, not mandatory, and setting up a fair process to resolve disputes.

In 2010 two Oregon public employee benefit boards adopted a value-based insurance design system that is showing results. **[Joan Kapowich](#), who administers Oregon's Public Employees' Benefit Board and Educators Benefit Board**, presents lessons learned from offering value-based tier benefit plans for 128,000 state and university employees and dependents and 155,000 public education employees and dependents. The plans increased copayments for overused or preference-sensitive services of low relative value and they covered preventive and high-value services at low or no cost. Kapowich says one lesson is that many purchasers will choose the path of least resistance and increase traditional cost sharing rather than add copay disincentives to their value-based benefit programs to avoid employee pushback.