Eliminating copayments improves adherence, reduces adverse events in nonwhite patients

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Research demonstrates that lowering copayments for cardiovascular medications results in better adherence and outcomes among all patients, but until now, little was known about whether lowering copayments could improve known disparities in cardiovascular care. New research finds that lowering copayments for medications following a heart attack could have a significant impact on reducing the racial and ethnic disparities that exist in cardiovascular disease.

These findings are published in the May issue of *Health Affairs*.

"African Americans and Hispanics with cardiovascular disease are up to 40 percent less likely than whites to receive secondary prevention therapies, such as aspirin and beta-blockers," said Niteesh Choudhry, MD, PhD, lead study author and associate physician in the Division of Pharmacoepidemiology at Brigham and Women's Hospital (BWH) and associate professor at Harvard Medical School. "Our research demonstrates that not only does eliminating medication copayments following a heart attack positively impact the disparity we know exists in cardiovascular care and improve outcomes for nonwhite patients, it also has the potential to dramatically reduce healthcare spending for this high-risk group."

Researchers analyzed self-reported race and ethnicity data for participants in the Post-Myocardial Infarction Free Rx Event and Economic Evaluation (MI FREEE) trial, and found that rates of medication adherence were significantly lower, and rates of adverse

clinical outcomes - readmission for a major vascular event or coronary revascularization— were significantly higher, for nonwhite patients than for white patients.

Researchers report that providing full drug coverage (no copayment) increased medication adherence in both groups. Among nonwhite patients, it also reduced the rates of major vascular events or revascularization by 35 percent and reduced total health care spending by 70 percent. Interestingly, providing full coverage had no effect on clinical outcomes and costs for white patients.

"As part of our ongoing efforts to promote racial and ethnic equality, we wanted to further explore whether financial responsibility resulted in different health outcomes based on race or ethnicity. This important level of detail helps us design products and services that more effectively meet our members' health needs," said Wayne Rawlins, MD, national medical director for Racial and Ethnic Equality Initiatives at Aetna and co-author of the study.

The study and analysis of medication adherence and the impact on racial and ethnic disparities is supported by an unrestricted research grant from Aetna to BWH and is part of ongoing collaborative work to understand the impact of health insurance on disparities in health care. Choudhry also receives research funding to study medication adherence from CVS/Caremark, who collaborated on the current study. Annual excess health care costs due to medication non-adherence in the U.S. have been estimated to be as much as $290 billion.

Provided by Brigham and Women's Hospital