

Eliminating Medication Copayments Reduces Disparities In Cardiovascular Care

-Author Affiliations

1. ¹Niteesh K. Choudhry (nchoudhry@partners.org) is an associate physician in the Division of Pharmacoepidemiology and Pharmacoeconomics, Brigham and Women's Hospital, and an associate professor at Harvard Medical School, both in Boston, Massachusetts.
2. ²Katsiaryna Bykov is a staff epidemiologist in the Division of Pharmacoepidemiology and Pharmacoeconomics, Brigham and Women's Hospital.
3. ³William H. Shrank was an assistant professor of medicine, Division of Pharmacoepidemiology and Pharmacoeconomics, Brigham and Women's Hospital at the time this work was done, and is now chief scientific officer of CVS/Caremark, in Woonsocket, Rhode Island.
4. ⁴Michele Toscano is program manager for the Racial and Ethnic Equality Initiative, Aetna, in Hartford, Connecticut.
5. ⁵Wayne S. Rawlins is national medical director for the Racial and Ethnic Equality Initiative, Aetna.
6. ⁶Lonny Reisman is chief medical officer, Aetna.
7. ⁷Troyen A. Brennan is chief medical officer, CVS/Caremark.
8. ⁸Jessica M. Franklin is an instructor in medicine, Division of Pharmacoepidemiology and Pharmacoeconomics, Brigham and Women's Hospital and Harvard Medical School.

Abstract

Substantial racial and ethnic disparities in cardiovascular care persist in the United States. For example, African Americans and Hispanics with cardiovascular disease are 10–40 percent less likely than whites to receive secondary prevention therapies, such as aspirin and beta-blockers. Lowering copayments for these therapies improves outcomes among all patients who have had a myocardial infarction, but the impact of lower copayments on health disparities is unknown. Using self-reported race and ethnicity for participants in the Post-Myocardial Infarction Free Rx Event and Economic Evaluation (MI FREEE) trial, we found that rates of medication adherence were significantly lower and rates of adverse clinical outcomes were significantly higher for nonwhite patients than for white patients. Providing full drug coverage 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. Providing full coverage had no effect on clinical outcomes and costs for white patients. We conclude that lowering copayments for medications after myocardial infarctions may reduce racial and ethnic disparities for cardiovascular disease.