EDITORIAL

When the Price Is Right: Beyond the Medical Risks and Benefits of Costly Therapies

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“The best things in life are free. The second-best things are very, very expensive.”
—Coco Chanel

Shared decision-making is experiencing a renaissance in medicine. Rather than the paternalistic approach of “Doctor Knows Best,” clinicians are encouraged to engage patients and caregivers in a discussion of the indications, risks, alternatives, and benefits of therapies framed by the patient’s goals, values, and preferences. This focus on the importance of engaging the patient is evident as recent society guidelines including those for hypertrophic cardiomyopathy, chest pain, and heart failure all incorporate shared decision-making in diagnostic and therapeutic algorithms.

However, although there is an increased emphasis on making patients active participants in their care, these discussions are often limited to the medical advantages and disadvantages of potential interventions; the financial implications of these therapies are often overlooked. By disregarding the financial consequences of newer, expensive therapies, clinicians are ignoring a significant component of their patients’ health journey. In one survey of 910 bankruptcy filers in the United States from 2013 to 2016, 66.5% noted that medical issues were a contributing reason for their bankruptcy. Even for those not driven to bankruptcy by the cost of medical care, there are medical impacts of financial toxicity. Of the 14,279 adults with atherosclerotic cardiovascular disease in the National Health Interview Survey, 12.6% experienced cost-related non-adherence with medical therapy, including 8.6% missing doses, 8.8% taking lower than prescribed doses, and 10.5% intentionally delaying a medication fill to save costs.

Nonetheless, clinicians often avoid discussing the costs of therapies with their patients. This financial blind spot on the part of clinicians stems from many sources of uncertainty: What is the true cost of medications for my patients? How do I frame the medical benefit against the financial risk? How do patients make cost–benefit tradeoffs, and will my patient be upset or insulted if I initiate such a discussion?

The elegant study by Rao and colleagues in this issue of the Journal of the American Heart Association (JAHA) is the first step toward answering some of these difficult questions. With a survey of adults self-identified with cardiac disease and sacubitril/valsartan as the hypothetical medication, the authors implemented a 3x2 factorial design to assess (1) willingness of patients with cardiac disease to take sacubitril-valsartan at 3

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commonly encountered out-of-pocket costs ($10, $50, and $100 monthly); (2) how priming patients to consider their financial situation with the Consumer Financial Protection Bureau’s Financial Wellbeing Scale affects their willingness to take sacubitril/valsartan; and (3) the impact of cost and cost priming on patients’ perceptions of the benefit of the medication.

Their findings were both intuitive and eye-opening. As expected, survey participants’ willingness to take sacubitril/valsartan increased as their out-of-pocket costs decreased. Not surprisingly, participants were also more willing to take sacubitril/valsartan if they had higher income and better financial well-being.

However, some findings were unexpected. Though the authors’ hypothesized that priming survey participants to consider their financial situation would make them less likely to take sacubitril/valsartan, in fact the opposite was true. Individuals who were primed to consider their personal financial situation before being told about the drug were more willing to take sacubitril/valsartan than those who were not. What could be the explanation for this unanticipated observation? One might assume that individuals would be less likely to pay more for a medication after considering their financial status. Of note, however, an exploratory subgroup analysis indicated the impact of cost priming was isolated to individuals with income of $75,000 and above. So, in this study, it appears that cost priming served to reassure financially secure individuals and render them more willing to take sacubitril/valsartan.

The most fascinating observation from this survey: as the hypothetical out-of-pocket costs of sacubitril/valsartan decreased, the perceived benefit of sacubitril/valsartan over angiotensin-converting enzyme inhibitors and angiotensin receptor blockers increased. This finding highlights my most important take-home message from this pivotal study: risk–benefit calculations aren’t just for clinicians; patients make them too. Furthermore, unlike clinicians, patients factor financial risks and benefits into their calculus—and the lesson here is that clinicians should as well.

The 2022 Guideline for the Management of Heart Failure offers a strong recommendation for use of sacubitril/valsartan: In patients with chronic symptomatic heart failure with reduced ejection fraction (HFrEF), New York Heart Association class II or III, who tolerate an angiotensin-converting enzyme inhibitor or angiotensin receptor blocker, replacement by sacubitril/valsartan is recommended to further reduce morbidity and mortality. The 2022 Guideline also provides value statements for treatments with high-quality published economic analyses. In fact, in patients with chronic symptomatic HFrEF, the 2022 Guideline notes that treatment with an angiotensin receptor–neprilysin inhibitor instead of an angiotensin-converting enzyme inhibitor provides high economic value. However, how this information should factor into a patient-centered discussion about the cost versus benefit will differ from patient to patient.

Thus, although the best medical therapy for patients with HFrEF will include sacubitril/valsartan, the importance of promoting optimal medical therapy must be balanced with the need to care for the whole patient and not just their heart. As the aphorism goes, “Perfect is the enemy of good.” Placing a patient on the most perfect (and costly) regimen for HFrEF at the expense of fixing their car or paying for their child’s dental care does not best serve the patient. The authors appropriately highlight this essential point: The reason to integrate medication cost discussions into shared decision-making is not to improve uptake of the medical superior and more expensive medications. Rather, this discussion offers an opportunity to mitigate financial toxicity and help patients make decisions that best align with their preferences and personal financial constraints and goals. As clinicians, our ultimate goal should be to help the whole patient (not just their heart), which involves contextualizing information about medications so they can make the decision that is best for their health, both cardiac and financial.

Although this study sheds light on the impact of financial considerations on patients’ decision-making, the findings are not (yet) readily translatable to clinical care. The study population included outpatients with cardiac disease, but not all cardiac disease is created equal. Cardiac disease could mean stable ischemic heart disease, paroxysmal atrial fibrillation, prior mitral valve repair—or HFrEF. Would patients with these stable, controlled cardiac conditions weigh financial strain versus medical benefits of a therapy the same way as patients grappling with the symptom burden and prognosis of HFrEF?

Survey participants in this study were provided a decision aid that indicated that after 2 years, there was an absolute 3% survival benefit for patients who took sacubitril/valsartan versus angiotensin-converting enzyme inhibitors or angiotensin receptor blockers. But for a survey participant to weigh the out-of-pocket cost versus benefit of a medication for a condition they do not have is not the same as imagining oneself as one of the lucky 3 patients whose life may be saved because of the medication. Will someone living with this fear put the same price on a longer life as a participant in a hypothetical survey?

Another concern for the generalizability of the study findings centers of the characteristics of the survey participants: 64% male, 82% White, 68% college educated, and 64% with good-excellent health. Not only are these demographic features inconsistent with the majority of patients living with HFrEF, but these participants would not be expected to suffer the same burden of health care disparities faced by vulnerable populations.
The limitations of the study are the basis for further investigations, and we should look forward with anticipation to the authors’ future work that it is hoped will address these issues: What is the impact of knowledge of out-of-pocket costs and cost priming on the willingness of patients with HFrEF to take sacubitril/valsartan? Can this model be applied to other medications in patients with relevant corresponding disease states? Will cost sensitivity and the impact of cost priming differ by age, sex, race and ethnicity, education, and health status?

The American philosopher Ralph Waldo Emerson said, “The first wealth is health.” Unfortunately, if Emerson had experienced our current health care system, he might have instead said, “Health can be maintained only with wealth.” Someday, we may live in a world where health can be maintained without wealth. But until then, a better understanding of both the financial and medical consequences of medical interventions is essential to provide the best care to patients. Rao and colleagues should be congratulated for having the creativity and courage to tackle this difficult issue and providing a pivotal first step toward integrating cost into patient-centered decision-making.

ARTICLE INFORMATION

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Disclosures
None.

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