THE TRUE COSTS OF NON-MEDICAL SWITCHING

Pharmacy benefit managers and health insurers are increasingly making coverage changes aimed at forcing stable patients onto treatments other than those their physicians recommend.

This intrusion into the physician-patient relationship, known as "NON-MEDICAL SWITCHING," erodes patient health and drives up monetary and societal costs.

ERODING PATIENT HEALTH; DRIVING UP HEALTH CARE & SOCIETAL COSTS

DEVASTATING HEALTH CARE OUTCOMES

- One way insurers can force a non-medical switch is by raising patient co-pays, making a treatment financially inaccessible.
  - For each 10 percent rise in patient co-pays, **medication use falls between 2 percent and 6 percent.**[i]
  - Doubling copays **reduces treatment adherence by 25 percent to 45 percent.**[i]
  - The consequences of medication nonadherence include **disease progression, reduced functional abilities, and a lower quality of life.**[ii]
- Switching treatments, even those the FDA deems "equivalent," can lead people with epilepsy to experience **breakthrough seizures.**[iii]
- For Crohn's Disease patients, even voluntary switching from one therapy to another is associated with **loss of effectiveness** within one year.[iv]

HIGHER HEALTH CARE COSTS

- Rheumatoid arthritis patients who incurred non-medical switching experienced the following over six months:
  - **42% more ER visits**
  - **12% more outpatient visits**[v]
- The **risk of hospitalization** for patients suffering from diabetes mellitus, hypercholesterolemia, hypertension, or congestive heart failure doubles with nonadherence – one potential outcome of raising out of pocket costs.[vi]
- People with epilepsy who recently switched **sought more in-patient and emergency care** than those that did not.[vii]
- Patients with rheumatoid arthritis, psoriasis, psoriatic arthritis, ankylosing spondylitis, or Crohn's disease who switch treatment due to a formulary change incur **37 percent higher all-cause medical costs** (which include hospitalizations, ER visits, and outpatient visits) and **26 percent higher total costs** than patients who are not switched.[viii]

NEGATIVE SOCIETAL IMPACTS

- Nonadherence to treatment medication regimens contributes direct annual costs of **$100 billion** to the U.S. health care system. Indirect costs **exceed $1.5 billion annually in lost patient earnings** and **$50 billion in lost productivity.**[ix]
- Psychiatric patients who stop taking their medications because of prescription drug coverage changes, utilization management, or copayment issues are **3.2 times more likely to be homeless.** Psychiatric patients who discontinue or temporarily stopped their medications are **more than twice as likely to be incarcerated in prison or detained in jail.**[x]

i. Goldman, D., G. Joyce, and Y. Zheng. "Prescription Drug Cost Sharing: Associations with Medication and Medical Utilization and Spending and Health." Journal of the American Medical Association. 4 July 2007; 298(1):61-69. Available at http://jama.ama-assn.org/cgi/content/full/298/1/61. See also Goldman, D., et al. "Pharmacy Benefits and the Use of Drugs by the Chronically Ill." Journal of the American Medical Association. 19 May 2004. 291(19), 2344–2350. Available at http://jama.ama-assn.org/cgi/content/abstract/291/19/2344
ii. Jimmy B, Jose J. Patient Medication Adherence: Measures in Daily Practice Oman Medical Journal. 2011;26(3):155-159. doi:10.5001/omj.2011.38.
iii. Epilepsy Foundation. (2009). In Their Own Words: Epilepsy Patients' Experiences Changing the Formulation of the Drugs They Use to Prevent Seizures. Available at http://www.epilepsy.com/sites/core/files/atoms/files/In-Their-Own-Words.pdf
iv. Van Assche, Gert, Vermeire, Severine, et al. Switch to adalimumab in patients with Crohn's disease controlled by maintenance infliximab: prospective randomized SWITCH trial. Gut Online. 10.1136/gutjnl-2011-300755, 2011.
v. SWITCHING FROM ADALIMUMAB TO OTHER DISEASE-MODIFYING ANTIRHEUMATIC DRUGS WITHOUT APPARENT MEDICAL REASONS IN RHEUMATOID ARTHRITIS: IMPACT ON HEALTH CARE SERVICE USE [AB1395]. Signorovitch et al. Ann Rheum Dis 2012;71(Suppl3):717
vi. Anon. Poor medication adherence increases healthcare costs.Pharmacoeconomics and Outcomes News. 2005;480:5
vii. Zachry III WM, Doan QD, Clewell JD, Smith BJ. Case-control analysis of ambulance, emergency room, or inpatient hospital events for epilepsy and antiepileptic drug formulation changes. Epilepsia. 2009;50(3):493-500.
viii. Claxo, J., Liu, J., Lin, Y., & Skup, M. (2015). Impact of non-medical switching on Healthcare costs: a claims database analysis. Value in Health, Volume 18 (Issue 3), pp. A252.
ix. Goldman D.P., et al. (2004). Pharmacy benefits and the use of drugs by the chronically ill. JAMA., 291(19): 2344-2350.
x. Alter, C.L., Crystal, S., Moszynski, J.S., Bae, D.S., Regier, D.A. Sanders, K.E., Stiber, M.R., West, J.C., & Wilk, J.E. (2009) Medicaid Prescription Drug Policies and Medication Access and Continuity: Findings from Ten States. Psychiatric Services, Volume 60 (Issue 5), pp. 601-610.

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