

COST-MOTIVATED TREATMENT CHANGES: *Implications for Non-Medical Switching*

What happens when patients' medications are switched for financial reasons instead of medical reasons? Does it affect their health? Their course of care? The overall cost of treating their condition?

The answers to these questions will impact patients and health policy alike. In the face of rising health care costs, some commercial health plans are attempting to switch stable patients to a less expensive medication in hopes of lowering costs. Known as “non-medical switching,” these changes can result from formulary changes that eliminate coverage for a patient’s medication or increase the level of required cost sharing. Non-medical switching can also occur as the result of insurer incentives or health plans’ decision to limit or reject copay coupons that make treatments affordable for patients.

The Institute for Patient Access began exploring the impact of cost-motivated treatment changes using Medicare Part B data. Future data on private health plans will shed more light on the impact of non-medical switching. But, for now, IfPA’s data suggest two critical concepts:

- 1.) Keeping patients stable on their medication can help to control overall costs for some patient populations.
- 2.) Changing treatments based on cost alone is not a choice that patients and insurers should make – or impose – lightly.

When is a patient stable on his or her medication?

When a medication is successfully treating a patient so that he or she experiences satisfactory relief from symptoms; may require several months of uninterrupted treatment.

NON-MEDICAL SWITCHING:

Compelling a stable patient to change medications for reasons unrelated to his or her health; often driven by health plan design or policies.

RESEARCH SUMMARY

The Medicare patients whose data informed IfPA's study took an IV or injected medication administered by their physician for the treatment of rheumatoid arthritis, Crohn's disease, or immunodeficiency between January 2012 and December 2013.

IfPA's analysis suggests that, when such patients undergo a potentially cost-motivated change in treatment, the switch has a significant impact on:

Overall costs: Patients with rheumatoid arthritis who switched to a less expensive treatment had Medicare payments that increased from the previous year.

- Payments for patients with no gap in therapy and **one** medication switch increased by \$8,711.52.
- Payments for patients with no gaps in therapy and **two** medication switches increased by \$8,827.32.

Meanwhile, stable rheumatoid arthritis patients experienced substantially lower annual cost increases than their peers did. Patients who were on the same treatment for 271 days or more had a yearly increase in payments of just \$201.24.

Course of care. After a patient switched medications once, his or her course of treatment was more likely to be interrupted by a second switch during the two-year data period.

- 8.1% of patients with Crohn's disease who were treated with Part B drugs switched therapies during the study period; 44.6% of these patients switched a second time.
- 9.9% of patients with rheumatoid arthritis who were treated with Part B drugs switched once; 32.6% of these patients switched a second time.
- 29.4% of patients with immunodeficiency who were treated with Part B drugs switched therapies; 46% of these patients switched a second time.

Moreover, *cost-motivated* switches led to a higher rate of second switches for rheumatoid arthritis patients.

- Of the patients with rheumatoid arthritis whose first switch was to a more expensive Part B drug, 25.9% switched a second time.
- Substantially more rheumatoid arthritis patients, 37.1%, switched a second time if their first switch was to a less expensive Part B drug.

These findings suggest that cost-motivated treatment changes can impact patients' health care utilization, course of care and related costs, a point that should resonate with both private and government health insurers.

WHAT DATA DID IfPA USE?

IfPA used the 2011-2014 Medicare 5% Standard Analytical Files. This study was a longitudinal analysis of patient use of medications and biologics covered by Medicare Part B, as well as Medicare spending on selected patients before and after a switching event. Analysis focused on patients with rheumatoid arthritis, Crohn's disease, and a diagnosis of immunodeficiency.

Projected to the national level, the two-year prevalence for each condition was:

- o Crohn's disease: 242,420 diagnosed patients (9.4% treated with Part B drugs)
- o Immunodeficiency: 57,640 diagnosed patients (17.7% treated with Part B drugs)
- o Rheumatoid arthritis: 1,521,660 diagnosed patients (6.5% treated with Part B drugs).

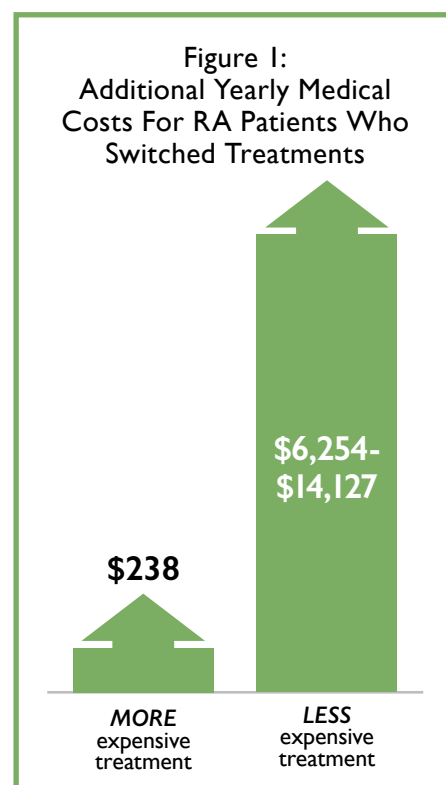
HOW DID IfPA DETERMINE THAT THE SWITCHES WERE ECONOMICALLY MOTIVATED?

Medicare data do not provide a rationale for changing a course of treatment and therefore cannot explain whether a switch is motivated by cost. Under Medicare Part B's current design, patients pay out of pocket for 20 percent of their medication's cost. Thus, for this analysis, researchers arrived at two logical conclusions:

- 1.) Switching to a higher-cost drug was most likely *not* cost motivated.
- 2.) Switching to a materially lower-cost drug *could be* cost motivated. These switches, therefore, framed the analysis of how cost-motivated switches can impact overall cost and care.

DID THE EFFECTS OF A SWITCH DIFFER DEPENDING UPON WHETHER IT WAS COST MOTIVATED?

Yes. For rheumatoid arthritis patients, switches to more expensive Part B drugs had a negligible effect on patients' use of medical resources in the next year, with a \$238.44 increase in yearly expenses. A switch to a less expensive Part B drug, conceivably a cost-motivated switch, resulted in additional yearly medical payments of \$6,254-\$14,127. (See Figure 1.)



Medication costs may also affect the future rate of switching. Of the patients whose first switch was to a more expensive Part B drug, 25.9% switched a second time. A statistically significant increase in switching was seen among patients whose first switch was to a less expensive Part B drug. Of these rheumatoid arthritis patients, whose initial switches could have been motivated by cost, 37.1% went on to switch a second time.

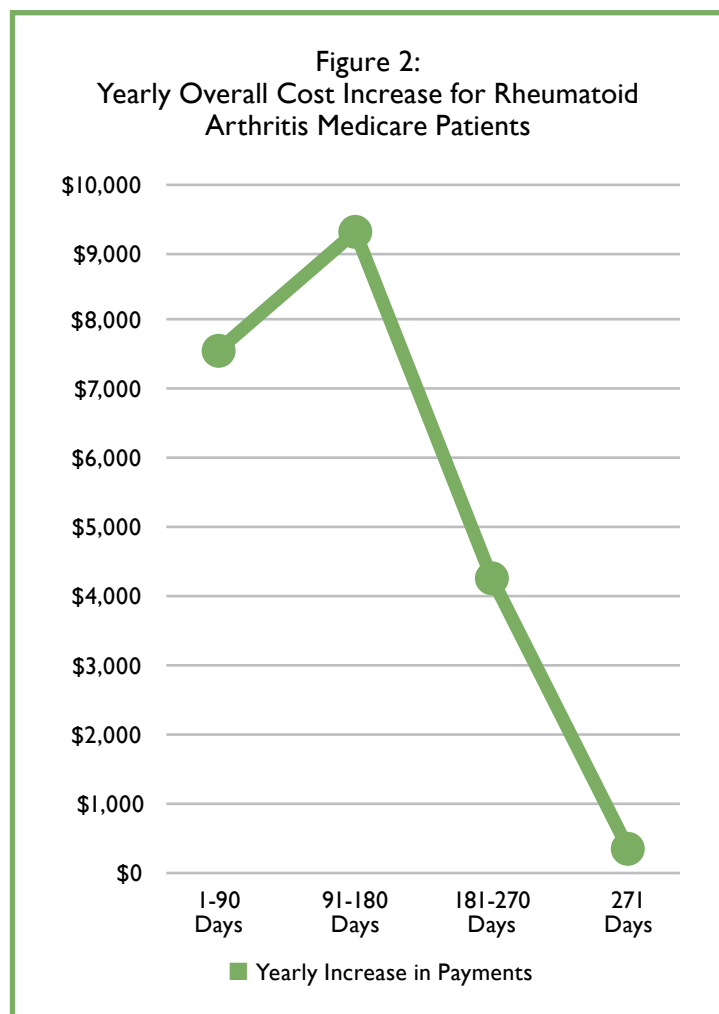
The data do not indicate motivation for the second switch, leaving open to speculation whether the first, cost-motivated switch may have resulted in an unsuccessful treatment option for patients. The data also do not show similar correlations between cost motivation and subsequent switches for patients with immunodeficiency or Crohn’s disease.

IF COST-MOTIVATED SWITCHING CAN INCREASE OVERALL EXPENSES, CAN STAYING STABLE ON A MEDICATION DECREASE EXPENSES?

For rheumatoid arthritis patients in particular, data show that Medicare patients who are stable on a therapy tend to have lower costs than patients who are switched or have gaps in therapy.

As shown in Figure 2, patients who were on the same treatment for 271 days or more had a yearly increase in payments of just \$201.24, suggesting that the most stable patients show the smallest year over year cost increases. Patients not stabilized on a treatment saw higher yearly increases:

- Patients on the same treatment for 181 to 270 days had a \$4,205.76 yearly increase.
- Patients on the same treatment for 91 to 180 days had a \$9,390.60 yearly increase.
- Patients on the same treatment for no more than 90 days had a \$7,629.96 yearly increase.



WHAT DO THESE FINDINGS MEAN FOR PATIENTS AND PATIENT ACCESS?

Additional research will shed more light on the impact of cost-motivated switching. Meantime, the data suggest that:

Switching can impact patient care.

An initial switch can set patients on the path for multiple switches. Thus, decisions to change a therapy should not be taken lightly.

Opting for a lower-cost medication may actually increase overall expenses.

Rheumatoid arthritis patients saw the lowest annual cost increases when they stayed stable on their treatment for 270 days or more. And when they underwent a cost-motivated medication switch, some saw their overall yearly Medicare expenses spike by more than \$14,000.

These data indicate that lowering medication costs may not always be a wise – or effective – strategy for reducing health care expenses.

Concerns about non-medical switching are warranted.

The data suggest that concerns about non-medical switching and its adverse consequences could be justified for certain patient populations. Further research is needed to more fully understand cost-motivated switches and their consequences.

Given the data in this report, however, health plans should approach issues of non-medical switching with caution, recognizing that switching the medicines of stable patients may impact patients' course of care and result in higher costs.



ABOUT THE INSTITUTE FOR PATIENT ACCESS

This research was conducted on behalf of the Institute for Patient Access by The Moran Company. The Institute for Patient Access is a physician led nonprofit 501(c)(3) research organization promoting the benefits of the physician-patient relationship in the provision of quality healthcare. To learn more visit www.AllianceforPatientAccess.org.