NON-MEDICAL SWITCHING
Myths vs. Facts

National Patient Advocate Foundation
The Patient's Voice | since 1996

MYTH: Non-medical switching is a transparent process.

FACT: Health insurers engage in non-medical switching by making formulary changes to remove coverage, increasing out-of-pocket costs or requiring more restrictions for a treatment – even in the middle of a plan-year. These changes are made without notifying the patient or provider.

MYTH: Non-medical switching saves money.

FACT: While non-medical switching can save money for health plans in the near-term, it can negatively impact patient health, and as a result, drive up system-wide and patient costs.

- Studies have found that 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.[1]

MYTH: Non-medical switching would never happen to me.

FACT: Non-medical switching is a growing practice by health plans and pharmacy benefit managers (PBMs) that affects an increasing number of patients each year.

- According to a 2015 survey by the American Gastroenterological Association, 60 percent of provider respondents reported that a patient's biologic medication was switched due to insurance company rules.[2]
- CVS/Caremark removed 34 drugs from its national formulary in 2012; it removed 124 in 2016. Express Scripts, the largest pharmacy benefit manager in the U.S., removed 48 drugs in 2014; it removed 80 in 2016.[3]

MYTH: Switching a stable patient's medication to a biosimilar or to another drug in the same class has no impact on that person's health.

FACT: Switching treatments for non-medical reasons can have negative and potentially irreversible consequences, including debilitating side effects and loss of disease control.

- Non-medical switching can lead people with epilepsy to experience breakthrough seizures. People with epilepsy who recently switched sought more emergency and in-patient care than those who did not.[4]
- Rheumatoid arthritis patients who incurred non-medical switching experienced 42% more ER visits and 12% more outpatient visits over six months.[5]
- For a patient on a biologic medication, a switch can result in immunogenicity— an immune response that can lead to a severe allergic reaction and potentially cause patients to no longer respond to therapy.[6]

MYTH: Non-medical switching is already illegal.

FACT: In most states, there are no limitations on payers' ability to manipulate formularies to force patients to switch their medications. Further, there is little-to-no regulation of PBMs at the state or federal level to restrict such practices.

1. Elaine Nguyen, Erin R. Weeda, Diana M. Sobieraj, Brahim K. Bookhart, Catherine Tak Piech & Craig I. Coleman (2016): Impact of non-medical switching on clinical and economic outcomes, resource utilization and medication-taking behavior: a systematic literature review, Current Medical Research and Opinion, DOI: 10.1185/03007995.2016.1170673.
2. American Gastroenterological Association National Survey, 2015.
3. Express Scripts 2016 Formulary Exclusions; CVS/Caremark 2016 Formulary Exclusions.
4. 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.
5. Signorovitch et al, SWITCHING FROM ADALIMUMAB TO OTHER DISEASE-MODIFYING ANTIRHEUMATIC DRUGS WITHOUT APPARENT MEDICAL REASONS IN RHEUMATOID ARTHRITIS: IMPACT ON HEALTH CARE SERVICE USE [AB1395], Ann Rheum Dis 2012;71(Suppl3):717.
6. Chao, J., Lin, J., Liu, 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.