



NON-MEDICAL SWITCHING OF MEDICATIONS

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ISSUE

You asked several questions about non-medical switching of prescription medication, which are answered below.

WHAT ARE "NON-MEDICAL SWITCHING" AND "COST-SHIFTING?"

"Non-medical switching" broadly refers to a change in a stable patient's medication for non-medical reasons, including a change in the patient's insurance plan or the availability of a less expensive but therapeutically equivalent drug. Non-medical switching may also be called "formulary-driven switching," "therapeutic switching," or just "switching."

In Connecticut, non-medical switching generally occurs when a patient requests his or her healthcare provider change a prescription because of an increase in copay or other out-of-pocket expense.

Non-medical switching generally does not refer to instances when a pharmacist substitutes a generic version for a brand name prescription drug.

"Cost-shifting" generally refers to a change in a health insurance plan that requires insureds to pay more for a specific service or benefit than they would have prior to the change. For example, an insurer shifting specialty medications to a higher formulary tier requiring a higher copay or coinsurance.

Cost-shifting may also refer to a health care provider's practice of compensating for losses from treating uninsured patients by spreading additional cost onto insured ones.

Cost-shifting is a component of cost-sharing, which is the amount or percentage an insured person must pay toward prescription drugs that are covered by a health insurance policy. For more information on how other states limit prescription drug cost sharing, see OLR Report [2016-R-0134](#).



WHAT ENTITIES CAN SWITCH A PATIENT'S MEDICATION WITHOUT THE PRESCRIBER'S PERMISSION?

According to the Connecticut Insurance Department, except for generic substitutions by pharmacists, only a prescriber (e.g., physician or advanced practice registered nurse) may switch, change, or write a new prescription. Pharmacists or pharmacy benefit managers may change coverage under the prescription drug insurance plan, but may not change the prescription itself.

In practice, in order to make a non-medical switch a patient must request his or her prescriber change a prescription. This is generally done in response to a formulary, copay, or coinsurance change that results in an increased out-of-pocket cost.

State law generally allows pharmacists to substitute a generic drug for a brand name prescribed drug when there is a cost savings ([CGS § 20-619](#)).

WHICH STATES PROHIBIT NON-MEDICAL SWITCHING?

We were unable to find any states that prohibit non-medical switching. However, several states have recently introduced legislation to limit the practice.

In Connecticut, [SB 6918](#) (2015), *An Act Concerning Changes To Prescription Drugs Dispensed To Certain Patients*, would have, under certain conditions, prohibited a pharmacist from changing an insured's prescribed drug without a medical basis and the express written consent of the prescribing practitioner. The pharmacist must be informed that the patient is medically stable and has a complex, chronic, or rare medical condition. The General Law Committee held a public hearing on the bill and took no further action. Public hearing testimony is available [here](#).

At least four other states had proposed legislation during 2015 or 2016 limiting pharmacists' ability to switch a patient's drug: Massachusetts ([HB 2054](#)), New York ([AB 3142](#)), Florida ([HB 95 and SB 182](#)), and Illinois ([SB 2131](#)). The proposed bill in Massachusetts also would have required pharmacists to disclose certain financial incentives related to non-medical switching. According to the legislative library, there has been no recent action on any of these bills.

We also contacted the National Conference of State Legislatures (NCSL) for any other states with current or proposed non-medical switching legislation. We will update this report with their response.

WHAT ARE THE CLINICAL AND ECONOMIC EFFECTS OF NON-MEDICAL SWITCHING?

While non-medical switching may decrease the cost of certain medications, some medical research indicates that it may also have unintended effects on clinical and economic outcomes, health care utilization, and patients' medication adherence. Such effects may include disease progression, adverse side effects to new medications, increased medication costs, and nonadherence to medication protocols.

A 2016 analysis by Nguyen et al. reviewed 29 existing scientific studies on non-medical switching that included 253,795 patients between 2000 and 2015. The authors found that non-medical switching was generally associated with negative or neutral clinical and economic outcomes and not with positive outcomes. This was particularly true for chronically ill patients who were medically stable before the medication switch occurred.

DOES MEDICATION NONADHERENCE RESULT IN INCREASED HEALTHCARE SYSTEM COSTS?

Generally, patients' nonadherence to prescribed medications may contribute to poor health outcomes as well as increased health care system costs. For example, a chronically ill patient who stops taking medication may experience disease progression, causing the patient to increase his or her number of doctor visits, hospitalizations, or emergency room visits, which increases total health care system costs.

A 2014 [analysis](#) by Iuga and McGuire reviewed existing medical literature on the impact of medication adherence (i.e., taking medication at prescribed times and doses) on health care costs in several chronic diseases, such as chronic obstructive pulmonary disease (COPD) and asthma. Health care costs are generally determined using administrative data to compare costs in patient populations who are medication adherent to those who are nonadherent.

According to the authors, between \$100 and \$300 billion of avoidable U.S. health care costs are attributed to medication nonadherence annually. But the impact on health care costs varies depending on the type of chronic disease. For example, studies demonstrated that COPD patients with higher medication compliance experienced fewer emergency department visits and hospitalizations, resulting in a reduction in overall health care costs (Iuga and McGuire, page 38). Conversely, studies of asthma patients demonstrated that increased medication adherence resulted in lower rates of emergency room visits, but increased overall health care costs (Iuga and McGuire, page 38).

The authors noted that differences in study designs, cost definitions, and patient populations make cost comparisons challenging. Additionally, many of the studies the authors reviewed were retrospective and observational, making it more difficult to show causality between medication adherence and changes in health care costs. For example, healthier people may be more compliant with medication protocols and engage in other healthy behaviors (e.g., diet and exercise changes) that impact their health status independent of the medication (Iuga and McGuire, page 37).

WORKS CITED

Iuga AO, McGuire MJ. Adherence and health care costs. *Risk Management and Healthcare Policy*. 2014;7:35-44. doi:10.2147/RMHP.S19801.

Nguyen E, E Weeda, et al. "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*, 32:7, 1281-1290

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