



ASTHMA & NON-MEDICAL SWITCHING



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The more than 25 million Americans with asthma experience wheezing, coughing, chest tightness and shortness of breath. Their condition can range from simply being uncomfortable to being lethal. More than 6 million asthma patients are children.¹

Asthma's prevalence has more than doubled in recent decades, yet the disease remains highly individualized. Patients' triggers, the severity of their symptoms, their ability to manage their condition, and their success with different treatments and delivery mechanisms varies.

While clinicians recognize this fact, health plans may not. Insurance coverage models too often embrace a one-size-fits-all approach that generalizes care based on rigid disease-state algorithms that prioritize the lowest-priced treatment options. The approach incorrectly assumes that patients are interchangeable, and that children are just small adults.

Increasingly, insurance companies and even pharmacies² may drive changes in asthma medication or delivery device that are unnecessary, expensive and even dangerous for patients.

Key Points



Clinicians choose the asthma medication and device that are best suited for each individual patient.



Through non-medical switching, health plans can compel patients to change their device or medication to save the health plan money.



Treatment changes based on cost alone can upset patients' ability to manage their asthma and introduce new health care expenses.

Asthma Devices

Asthma medications are typically inhaled, drawing the medicine directly into the respiratory system. There are several treatment options, and health care providers work to identify the correct combination of medicine, dosage and delivery devices for each patient. A correct medicine with the wrong delivery device may be of little value.

While there are numerous brands and formulas of asthma treatments, there are basically two types of inhaled medication for asthma sufferers:

- Anti-inflammatories, typically steroids such as mometasone and fluticasone.
- Bronchodilators, such as albuterol and salmeterol, which open up breathing passages in the chest and bronchial tubes.

These medications are sometimes combined in a single “combination inhaler.”

Meanwhile, there are three common devices currently used in asthma treatment, each with its own strengths and weaknesses.

These are: metered-dose inhalers, dry powder inhalers and nebulizers, depicted on page 3. Other less-common delivery options include Respimat®, a novel handheld device that delivers a gentle mist.³

The specific combination of drug, dosage, and device is selected by individual health care providers based on their knowledge of each patient. For instance, a metered-dose with a spacer might be best for children, as it presents fewer challenges with timing and coordination.

Children with more severe asthma, as well as elderly patients, often respond better to nebulized medicine. Athletes, active teens and young adults may be more adherent with a dry powder rescue inhaler since it is more portable. Patients often have strong preferences about the type of device they use.

Like asthma medications, devices are neither equivalent nor interchangeable. Yet insurance companies often treat them as such, compelling patients and physicians to follow treatment regimens dictated by finances, not by function.



Asthma Devices: At a Glance



METERED-DOSE INHALER (MDI)

L-shaped handheld devices with a pressurized canister containing an aerosol.

Benefits

- + Compact
- + Easy to use (1-step)
- + Does not require a deep breath to work properly

Issues

- Requires a spacer device for maximum effectiveness
- Sometimes unclear how much medicine is left in device
- Requires correct timing with inhalation

Cylindrical or disk-shaped handheld device that dispenses pre-measured doses of fine powder.

Benefits

- + Compact
- + Does not require spacer
- + Does not require timing with inhalation
- + It's usually clear how much medicine is left in device

Issues

- Can commonly cause other issues, such as thrush
- Requires deep inhalation, which can be difficult for some asthma patients



DRY POWDER INHALER (DPI)



NEBULIZER

Electrically powered device that turns liquid medication into an easy-to-breathe mist.

Benefits

- + Easy to breathe in medicine
- + Does not require timing breath
- + Does not require deep inhalation

Issues

- Bulky, difficult to transport
- Usually requires electrical outlet
- Expensive to purchase

Asthma & Access

Asthma medications are prescribed by physicians who work with patients to determine the best course of treatment. Most cases require some amount of trial-and-error in tailoring the medicine, the device and the dosage for each patient.

However, like many other prescription medicines, asthma medications are expensive. Recent studies estimate that the average annual medical costs for asthma patients are over \$3,200, including over \$1,800 for medications,⁴ representing more than \$40 billion annually in prescription drugs.

To contain these costs, insurance companies negotiate with manufacturers to determine which drugs are available to patients on particular plans. In such cases, decisions about what is available to patients are based

not necessarily on medical science but upon financial interests. For instance, insurance companies routinely require patients to undergo step therapy, when a patient is required to try the insurer-preferred option – typically older, less expensive treatments – before his or her insurance pays for the treatment prescribed by the patient's doctor.

In addition, pharmacists are sometimes encouraged to substitute generic versions of medications in place of brand-name drugs, even when there are differences in the medication's delivery system. This might mean switching, for example, from a dry powder inhaler to a metered-dose inhaler.

These policies fuel the growing problem of non-medical switching.



Non-Medical Switching

Non-medical switching poses concerns for patients, particularly those who are managing their asthma successfully with the use of sophisticated medicines. Non-medical switching occurs when health plans alter their prescription drug coverage to drive a patient toward a drug that's less expensive for the insurer. This may entail limiting the formulary of approved drugs so that a patient's drug is no longer covered, or pricing the patient out of access by placing his or her drug on a specialty tier with a prohibitively expensive out-of-pocket requirement.

Such a switch can disrupt a patient's ability to manage his or her disease.

It also presents the challenge of educating patients on how to use a new device. Patients may not recognize the need to visit their physician's office and learn about the new device. In the event that patients do, time-strapped physicians and their staff face the challenge of fitting proper education for these patients into an already strained schedule.

Despite the obvious risks, patients with chronic diseases such as asthma often find themselves the targets of non-medical switching policies. This makes sense from a financial standpoint, as treatment for chronic disease accounts for the vast majority of health care costs.⁵ However, patients with chronic diseases are arguably among the most dependent upon medication for day-to-day functioning and most affected by disrupting treatment.

Furthermore, while non-medical switching aims to rein in health care costs, it can ultimately increase overall costs for both patients and insurance companies. The change may cause side effects, and too often leads to additional doctor visits or even hospitalization.

Aside from the medical risks, non-medical switching can waste valuable time. Patients and physicians put significant effort into tailoring treatments to each individual. Non-medical switching may force patients to repeat the trial-and-error process of adjusting dosage, which could also require additional lab tests and doctor visits. Furthermore, a recent study showed patients who underwent a cost-motivated treatment change were more likely to experience another switch after the first, potentially costing even more.⁶



Conclusion

For patients with asthma, the ability to breathe can depend upon the ability to obtain life-saving inhalers prescribed by their physician. While most asthma cases are manageable, the disease can still be deadly. In 2015 there were more than 3,600 asthma-related deaths.⁷

When insurance companies interfere with patients' ability to obtain medication, it can have serious – even lethal – consequences. Nowhere is that clearer than with asthma medication, which literally allows people to draw their next breath.

Some states either have or are considering legislation limiting insurance companies' ability to compel patients to switch medications. Furthermore, recent surveys showed that the majority of patients with chronic diseases, approximately half of the U.S. population,⁸ approve of such measures.⁹

The wellbeing of Americans with asthma requires that lawmakers not only consider the impact of non-medical switching but also set reasonable limits for health plans. Only then can America keep physicians and patients, not insurance companies, in charge of medical treatment decisions.

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