Children's Hospital of Philadelphia
PolicyLab

How One Administrative Change Can Significantly Harm Kids with Asthma

Population Health Sciences

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We recently released a new policy brief that highlighted the troubling story of three-year-old Lauren (name changed for patient privacy) who has persistent asthma:

"[Lauren's asthma] was poorly controlled until three months ago when she began using a daily controller inhaler. With this inhaler, she could use a device called a "spacer" to make it easier for her to breathe in the medicine. Since starting this new medication, her family noticed that she hadn't had a flare up and rarely needed her rescue medicine. They started to trust the medicine and made it part of her morning and evening routines.

However, her insurance company recently renegotiated medications on their formulary and left out this particular drug that seemed to help Lauren so much. Instead of replacing it with a similar generic or well-studied brand name medication that Lauren could use the same way (a metered-dose inhaler), they included only one medication option in this class (a dry-powdered inhaler). This medication needs to be taken differently (without a spacer) and isn't reliable for kids her age as it requires a strength of inhalation and level of coordination that they rarely have. When Lauren used this new inhaler, the medication ended up in her mouth and her digestive system instead of her lungs, essentially leaving her without any therapeutic effect.

Within two weeks of starting this new medicine, her mother called the pharmacy and doctor's office multiple times concerned that Lauren doesn't seem to be able to use the inhaler. A week later she had a flare up and, despite her mother's best efforts to treat her symptoms with her rescue inhaler, she was admitted to the hospital with a severe asthma attack."

When insurance companies change drug coverage to similar medications for which they can negotiate a lower price, as Lauren's insurance company did, it is called non-medical formulary switching (NMFS). Changing formulary medications for contractual rather than clinical reasons is a potentially harmful practice. Unfortunately, this has become standard with health plan formularies changing up to *twice yearly* with no forewarning for patients or physicians. In fact, often the first time a physician is aware of the switch is when a parent or pharmacy contacts them because the insurance company denied the regular prescription.

As a pediatrician for over 30 years and medical director of the Community Asthma Prevention Program for more than 20 years, I have seen how important it is to have stable medications for all chronic conditions, especially asthma, the most common chronic medical condition in children.

The direct impact of NMFS on youth asthma patients

Asthma disproportionately impacts low-income and minority populations, who already experience greater difficulties with health care access and disease management. Children with asthma can be exposed to asthma triggers in places where they live, play, learn and pray such as their homes, schools and daycare facilities and places of worship.

Families and their health care providers work hard to find an asthma management plan that works financially, logistically and medically for the child. When commercial insurance companies change coverage for asthma

medications, families must either pay more out-of-pocket for the original medication (which they are often unable to afford), or switch medications and put their child at risk for increased asthma flare ups and hospitalizations.

With different medications, children and their families are forced to adapt to a different asthma care routine and learn new dosages and delivery systems, all for a medication that may not even have the same efficacy. Most of the time the pharmacist assumes that patient is receiving instruction for taking the medication from the health care provider. But if the provider is not aware of the formulary change, they cannot assess whether the child is using their new inhaler properly. In the case above, the new medication given to Lauren required a new technique for inhalation that is almost impossible for a three-year-old. But the parent did not realize that Lauren was at risk until she ended up in the emergency room.

Furthermore, creating routines in a busy household is difficult. When dosages or frequency of dosages are changed, children are less likely to get their medications. Children with asthma have been found to adhere to their prescribed medication at best 50 percent of the time; NMFS can lower this even more.

Action steps we can take to reduce the harmful impacts of NMFS

Reducing high health care costs is important, but we must consider and prioritize health outcomes. In the case of NMFS, health outcomes are often worsened and costs may actually increase.

POLICYLAB POLICY BRIEF | SUMMER 2018
INFORMING CHILDREN'S HEALTH POLICY THROUGH RESEARCH

WHEN MEDICATION SWITCHING THREATENS CARE OF CHILDREN WITH ASTHMA

CHILDREN WITH ASTHMA CAN SUFFER BECAUSE OF FREQUENT AND UNNECESSARY CHANGES TO THEIR MEDICATION COVERAGE.

Insurers often use a tactic known as non-medical formulary switching (NMFS)—changing coverage to similar drugs for which they can negotiate a lower price—as a way to reduce prescription drug prices. While we should applaud efforts to reduce the high cost of prescription drugs generally, the use of NMFS is frequently misguided. It can have direct impacts on patients and their care, often forcing families to either switch to a different, newly covered medication that might result in negative health outcomes or pay much more out of pocket to keep the medication that is working for them. Exacerbating the problem, insurers frequently switch medications because the lower price for an alternative brand-name drug is temporary, requiring another change in medication when that deal ends. Children with asthma – the most common chronic medical condition in children – rely on regular use of medication to stay healthy and are especially vulnerable to negative health impacts resulting from these changes.

This brief identifies the challenges associated with NMFS, their consequences for children with asthma, and guidance on ways to improve practices to ensure stable, continuous medication management so children with asthma and others who rely on regular medication can stay healthy.

BACKGROUND ON NON-MEDICAL FORMULARY SWITCHING (NMFS).

NMFS is a common practice for both private insurance plans and in programs like the Children's Health Insurance Program (CHIP) and Medicaid. In theory, NMFS is intended to reduce the cost of medical care by shifting prescriptions to equally effective but less costly medications (e.g. newly introduced generics), a practice that we encourage when new medications are actually equally effective and less costly. In reality, pharmacy benefit managers often negotiate with pharmaceutical companies for short-term discounts, which can lead to temporary promotion of another brand name medicine instead of generic medicines that have more price stability. The resulting frequent changes to drug coverage can cause negative health outcomes and greater costs in the long run.[1,2]

Yet, NMFS has become routine for those who make decisions about which medications to cover, even though the evidence does not suggest it is a clinically or cost-effective practice.

KEY TAKEAWAYS

Non-medical formulary switching (NMFS) is used by insurers to limit coverage of prescription drugs to medications for which they can negotiate a lower price.

Frequently changing which drugs are covered without a medical reason can disrupt patient care, lead to worse health outcomes and, ultimately, increase health care costs.

Children with asthma are particularly vulnerable to negative health consequences caused by NMFS.

Thoughtful policies can inform the appropriate use of NMFS to help patients stay healthy and save health care dollars.

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PolicyLab's new policy brief on NMFS offers recommendations on how insurers (aka health plans), clinicians and families can reduce its harmful impacts. We are working to share this brief and use it as a point of collaboration with insurers and others involved in childhood asthma care. The response I've received from health plan administrators has been mixed. For some health plans, decisions are made by a pharmacy and therapeutic committee without input from practicing clinicians. This can create barriers to understanding patient implications for a particular medication change. Other insurers are more responsive and work with physicians to adapt the formulary when we point out the problems with the medication switch. At the end of the day, if we really want to provide the best care for children with a diagnosis of asthma, we need a physician-informed, unified formulary which includes at least one child-friendly asthma controller medication that does not change unless the medication goes off the market.

If you have experienced issues related to NMFS, feel free to reach out to us, and help us talk more about this important issue by sharing our resources with your networks.

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