

Mental Health Care & Non-Medical Switching



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Non-medical switching is a complicated obstacle for mental health care providers and their patients to overcome. How can policymakers curb this practice?

An estimated 52.9 million adults aged 18 or older in the United States suffer from mental illness, including 14.2 million with severe mental illness.¹ Around one in six U.S. adults takes a psychiatric medication, such as an antidepressant, sedative or antipsychotic.²

Health care providers who treat mental health disorders assess both the mental and physical aspects of psychological problems. Prescription medications are among the most powerful tools they have for treating mental illness. Finding the right balance of therapies, however, often requires a protracted trial-and-error process. During this process, providers are carefully building trust with their patient, which may be challenging given the symptoms often associated with chronic mental illness.

The insurance industry practice known as non-medical switching, where a stable patient's treatment regimen is changed for cost-cutting reasons rather than for efficacy, side effects or adherence, is particularly disruptive for mental health care providers and patients living with mental illness.³

Seeking Help for Mental Health

Managing one's mental health can be a challenge. But for those with a genetic predisposition, family history or other risk factors related to mental illness, it can be overwhelming simply to recognize that they have a problem that warrants medical intervention.

It requires courage to take that critical first step, seeking out a mental health care provider, which may entail researching and seeing several different providers before settling on one whose approach feels comfortable. Some patients may also work with a therapist or licensed counselor at the same time.

Yet a number of external factors may hinder access to mental health treatment for millions of Americans who desperately need it.

Some may only be temporary, such as the stress of the COVID-19 pandemic, during which 40% of adults reported struggling with their mental health or substance abuse.⁴ Other barriers to access are long term. For example, the U.S. Health Resources & Services Administration recently reported a severe shortage of psychiatrists, which is likely to continue through the end of this decade.⁵ There are also more permanent obstacles, including the fact that 60% of rural residents live in designated mental health provider shortage areas.⁶

Effective Treatment Requires Trial and Error

Once a mental health care provider has made a diagnosis, which can take several weeks or months of consultations with a patient, there is a wide range of treatment and medication options. Those may include antidepressants,

antipsychotics, sedatives and anxiolytics, hypnotics, mood stabilizers, and stimulants. The hundreds of drugs available under each of these classifications can have their own indications and contraindications.⁷

Consequently, a trial-and-error approach, where you try to find the best fit, is often necessary. In fact, patients may have to switch medications or dosages several times before their health care provider finds the ideal combination of treatments that works for their own unique brain chemistry. Each of these trials can last weeks or months.

For example, most panic disorder patients have a favorable response to serotonin reuptake inhibitors, or SSRIs. But fully 30% will not be able to tolerate these medications or will have an unfavorable or partial response. So, if a patient responds poorly to an initial trial of an SSRI, the provider must then decide whether to adjust the dosage, switch to a different drug of the same class, or try a less preferred alternative, such as a slower-acting benzodiazepine, which has its own safety and efficacy profile to consider.⁸

Even after these trials, a patient still may not have demonstrated significant progress. That is why mental health care providers cannot take a one-size-fits-all attitude in treatment.



Insurers are simply not qualified to interfere with medical decision making.

Non-Medical Switching Disrupts Progress and Emotional Stability

Switching medications multiple times during an initial trial-and-error phase is part of determining the right treatment, based on well documented science and medicine. It's directed by a mental health care provider's expertise, entails face-to-face consultation with the patient, and incorporates real-world data and observations.

Non-medical switching, in contrast, entails none of these things.

Non-medical switches are often made at the beginning of a new coverage year, but they can be handed down any time and with little warning. An insurer may suddenly increase a patient's out-of-pocket requirements, reduce their plan's maximum coverage, impose new restrictions on a drug's use or remove it from their formulary entirely — without any scientific reasoning. It is especially egregious because switches are frequently made after patients have put in the work to find an effective treatment regimen and are finally stabilized.

A stable patient can have his or her peace of mind disturbed and risk relapse following a non-medical switch. The loss of control can cause the patient to feel uncertain, powerless

or resentful. For those who were initially reluctant to seek treatment, a switch can destroy the self-esteem gained with treatment by invalidating their experience with or emotional attachment to a given drug.

Indeed, in a nationwide poll of patients who experienced non-medical switching firsthand, 83% claimed the switch left them feeling “frustrated,” while 72% felt “confused.” Two-thirds said it affected their productivity at work, and over 40% said they couldn't care for their children, spouses or other family members following their non-medical switch. Critically, almost 40% of patients said their new medicine was not as effective as their original, while nearly 60% reported complications.⁹

Clinicians are increasingly acknowledging that non-medical switching is counterproductive and sometimes cruel. In fact, the American Medical Association recently passed a policy resolution that “strongly recommends that the switching of therapeutic alternates in patients with chronic diseases who are stabilized on a drug therapy regimen be discouraged.”¹⁰

Yet the practice continues. A 2020 study found that requests for a non-medical switch for psychoactive medications was reported as frequent or very frequent by 60% of psychiatrists. The consequences their patients experienced were deeply troubling, with 66% seeing their patients suffer from new side effects after the switch.¹¹



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A Non-Medical Switch Can Put Further Gains Out of Reach

Non-medical switching doesn't merely cause short-term inconvenience, then allow the physician and patient to return to where they left off. To the contrary, with a mental illness, trying an alternative drug for even a short period of time, solely because an insurer requires it, can eliminate months of accumulated progress.

And if a switch happens to be imposed at the peak of a successful course of treatment, with a mental health patient who has reached an optimal level of stability, the possibility of even greater outcomes is lost permanently. Further gains that once seemed within their grasp may now be out of reach indefinitely.

Non-medical switching can also undermine patient adherence, which is already a challenge for many patients. People living with mental health conditions sometimes resist the idea that they have such a condition or that they require treatment for that condition. Arbitrary changes imposed by their health insurer may reinforce their hesitancy.

The Acute Danger of Non-Medical Switching to Severe Cases

Non-medical switching seems to happen more often with antipsychotic medications. This trend can be extremely dangerous. Bear in mind that mental health care providers regularly treat patients suffering from serious — and sometimes volatile — mental health conditions, including schizophrenia, major depressive disorder and advanced memory disorders. If untreated, these patients can act out violently. These episodes could lead to hospitalization, harm to others or even attempts at suicide.

Removing a patient from an effective treatment for even one month may induce a downward spiral that rapidly displaces several months or even years of progress. So, for those suffering from severe psychosis or substance use disorder, a relapse may not just be a setback. It may very well bring about the end of a patient's overall quest to get well.

Removing a patient from an effective treatment may induce a downward spiral.



Non-Medical Switching Undermines Provider-Patient Relationships

Because mental illnesses often manifest symptoms like anxiety, paranoia, confusion, inability to concentrate, and other behavioral issues related to trust and security, the relationship between the health care provider and patient can be profoundly disturbed if a third party suddenly interjects with demands to switch medicines. The faith in and rapport with a provider may be the only thing that keeps a patient on the right path.

If a patient suddenly has difficulty accessing a medication or discovers it now cost hundreds or even thousands of dollars, they may lose trust in the provider's competence or motives. They may question the overall course of treatment, which can cause misplaced frustration or even anger.

Making matters worse, non-medical switching can detract from time that mental health care providers would otherwise spend with their patients. The process often requires providers or pharmacists to devote precious time to resolve administrative hurdles, file additional paperwork, or deal with phone calls or emails.

Meanwhile, a patient's condition may increase the likelihood of miscommunication or withdrawal, further complicating the process. Every day that passes without the patient taking his or her prescribed medication, additional symptoms could reemerge.

Non-medical switching interjects uncertainty between a provider and their patient, taxing a relationship that is central to treatment.

The True Cost of Non-Medical Switching

Non-medical switching occurs purportedly to save money, but it's not clear that it does so over the long-term — for the patient, the insurer or the health care system. One study found that the practice actually increased costs in the year following the switch, mostly due to follow-up visits and additional laboratory tests and other redundant procedures.¹²

The insurance industry promotes the false narrative that clinicians — if left to their own decision-making — automatically choose the newest, most innovative and most expensive treatments. There is no evidence to suggest this is the case.



The truth is often that better outcomes save money. A stable patient has likely returned to school, work or family, so they're being productive and providing returns on health care investment. An avoidable relapse sacrifices those gains and may cause additional hospitalization. There are often consequences to the patient's overall long-term health that could further increase health care costs down the line.



Conclusion

It is time for state and federal policymakers to boldly pursue regulations to prohibit or at least limit non-medical switching, especially when it comes to mental health patients.

Stable patients must be allowed to keep their medication. If a switch cannot be avoided, then patients and mental health care providers at least deserve enough notice to allow for responsible weaning from an existing medication. And if a non-medical switch is imposed, a straightforward appeals process is warranted. Additionally, discriminatory formulary changes should be prohibited to prevent insurers from unfairly moving medications to higher formulary tiers simply to push an unmanageable portion of the costs onto patients.

Non-medical switching allows insurers to pursue profits at the expense of patients. Especially for people living with mental health conditions, the cost of this practice — in terms of lost progress, recurring symptoms, a fractured physician-patient relationship and lost potential for future improvement — is simply too high.

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