

# Medication Costs Harm Patients With Multiple Sclerosis

Marc R. Nuwer, MD, PhD, and Kevin Patel, MD

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## Correspondence

Dr. Nuwer

MNuwer@mednet.ucla.edu

Governmental policies aimed to reduce costs to patients of multiple sclerosis (MS) disease-modifying therapy (DMT). Closing the part D coverage gap intended just that—to reduce patient cost burden. Hartung et al.<sup>1</sup> found this policy ineffective. Simultaneous pharmaceutical price increases offset reductions in patients' personal costs.

Physicians face compound problems when trying to deliver quality health care to patients with MS. Preauthorization issues, denials, and appeals have become increasingly onerous over the past decade. Physicians specializing in care of patients with MS repeatedly cope with medication denials and spend seemingly endless hours wasting time in patient visits trying to navigate idiosyncrasies of insurance plans. Conversations with insurance company representatives and regular drafting of letters have become a fact of life for MS neurologists. The administrative burden is quite high. The substantial commitments of time and effort contribute to staff turnover and physician burnout. Physicians have been dropped from insurance carriers' preferred provider lists, increasing the cost for patients with MS to see specialists. The MS specialist physicians are dropped from insurance panels because their overall expense profile is high compared with other physicians. It is high because of DMT prescriptions. This perverse situation punishes specialized physicians for providing quality medical care. It punishes patients by requiring a higher cost to see a specialist and purchase medication.

There are substantial costs in terms of patient morbidity as well. Patients denied medication for months end up suffering relapses while they are unable to obtain medication. This is a phenomenon of carrier-caused relapse was rare a decade ago, something we did not experience then despite caring for many outpatients with MS.

As an example, take an outpatient seen last week. She is a 49-year-old former serial marathon runner and commercial fitness trainer. In 2009, she developed optic neuritis in her right eye, and then, 8 months later, she had a second episode in the left eye. In 2014, she developed girdling pain around her torso and was diagnosed with MS. She was initially started on interferon beta-1a, but she tolerated this poorly. She switched to teriflunomide on which she was clinically stable. In late 2016, she was forced to discontinue her DMT because of rising medication costs. The next year she developed right leg weakness from which she had a poor recovery. She requires now a walker to ambulate. She has had to close her fitness training business. She is now unemployed.

This trade-off in cost vs health is very unfortunate. It is happening over and over. The rate of noncompliance is increasing.<sup>2-5</sup> Patient medication noncompliance in the United States too often is economically driven, not by patient choice. The National Academy of Sciences called the pharmaceutical industry's pricing "opaque".<sup>6</sup> Recent studies showed a window of opportunity to begin early DMT, and that missing that window results in long-term disability.<sup>7,8</sup> Pharmaceutical price increases coupled with insurance carrier denials, hassle, and delays may force patients to miss the opportunity to avoid long-term disability.

The government's program to close the part D coverage gap to decrease patient cost has turned upside down. Pharmaceutical companies increased prices so much so that patients suffer an

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Department of Neurology, David Geffen School of Medicine at UCLA.

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adverse economic impact, an economically based forced noncompliance, and deteriorating health outcomes.

Hartung et al. call for US legislation to address this medication affordability crisis. That seems like the unfortunate next step in this process. Meanwhile, physicians should continue to advocate for their patients' best health care interests. Early DMT is valuable to avoid long-term disability in patients with MS.

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