SCHIZOPHRENIA

Considerations on the cost of illness in the US

Schizophrenia symptoms involve a range of cognitive, behavioral, and emotional dysfunctions[1]

Earlier age at onset has been seen as a predictor of worse prognosis[1]

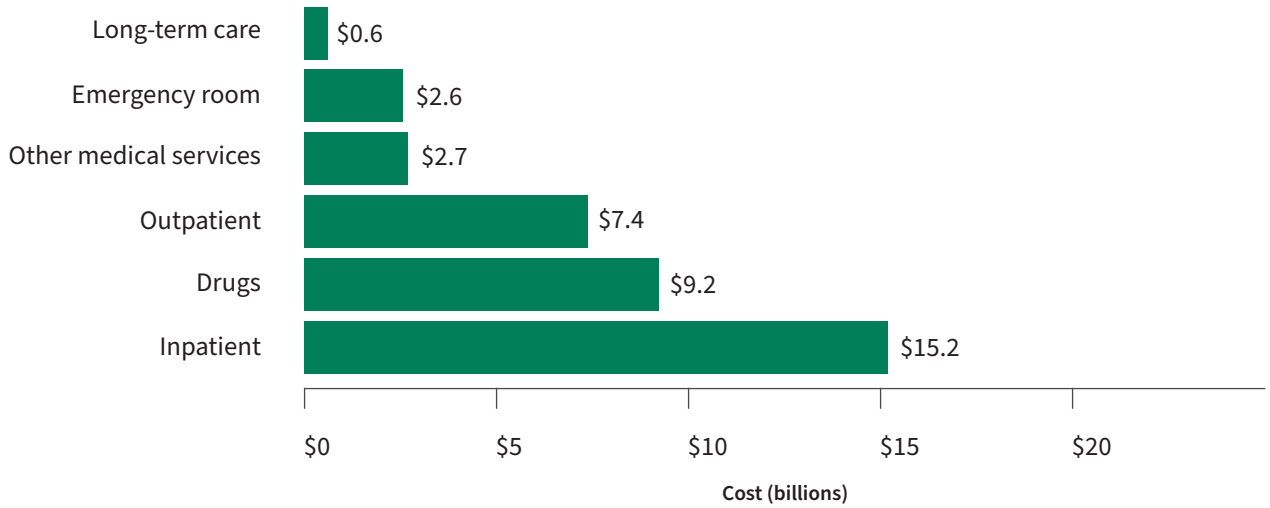
One study found that the mean PPPM/PMPM cost was **$1806 vs $419** for a matched population without schizophrenia[2]*

>70% of patients with schizophrenia were shown to be nonadherent to their antipsychotic medications, which contributes to higher costs[3]†

Excess direct health care costs of schizophrenia in 2013 were ~$38B

out of an overall estimated excess cost of ~$156B (based on a prevalence of 1.1%)[4]

Components of **excess direct health care costs** for patients with schizophrenia in the US in 2013[4]



Study description: A retrospective, claims-based analysis of direct health care costs, direct nonhealth care costs, and indirect costs associated with schizophrenia for 2013. Direct health care costs were estimated using a matched cohort design. Patients with a documented diagnosis of schizophrenia were matched (on a ratio of 1:3) to those without schizophrenia and were classified into 3 samples: commercial, Q1 2010 to Q2 2013 (n=31,698); Medicare, Q1 2010 to Q2 2013 (n=6629); and Medicaid, Q1 2010 to Q4 2013 (n=68,864). Excess costs attributed to schizophrenia are the incremental costs estimated based on the difference between an individual with schizophrenia and one without schizophrenia. Estimates were based on a schizophrenia prevalence rate of 1.1% (the total US schizophrenia population in 2013 was estimated at 3,477,417).

Limitations: Direct health care costs were estimated from the amounts reimbursed by payers and incurred by patients and may not reflect the full costs incurred. They also do not include those of patients with undiagnosed schizophrenia. Patients covered by military insurance were assumed to incur the same costs as those covered by commercial insurance, and those eligible for both Medicare and Medicaid were assumed to incur the same costs as patients covered by Medicare. Some patients with recurrent enrollment gaps may not have been included in the analysis. For estimating indirect costs, this study used the human capital approach, which values productivity costs of morbidity and mortality; other methods may provide different estimates. Because of a lack of information about the schizophrenic population, some incremental costs could not be assessed.

*Based on a claims-based analysis of 8985 patients who were newly diagnosed with schizophrenia and who had no claim coded with schizophrenia in the 12 months before the index date. Individuals (13 to 64 years) had ≥2 claims with a diagnosis code for schizophrenia on separate dates during 2011 from the Truven Health MarketScan database. The mean cost PPPM/PMPM was compared with the costs in a demographically adjusted commercially insured population without schizophrenia, matched for age and sex.

†Nonadherence was defined as proportion of days covered <80%. Student's t-test for differences in health care utilization between adherent and nonadherent populations in a weighted sample found that the nonadherent population had more outpatient visits and office visits compared with the adherent population.

PPPM = per patient per month; PMPM = per member per month.

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References:

1. American Psychiatric Association. Schizophrenia. In: *Diagnostic and Statistical Manual of Mental Disorders*. 5th ed. American Psychiatric Association; 2013:99-105.
2. Fitch K, Iwasaki K, Villa KF. Resource utilization and cost in a commercially insured population with schizophrenia. *Am Health Drug Benefits.* 2014;7(1):18-26.
3. Desai R, Nayak R. Effects of medication nonadherence and comorbidity on health resource utilization in schizophrenia. *J Manag Care Spec Pharm*. 2019;25(1):37-46. doi:10.18553/jmcp.2019.25.1.037
4. Cloutier M, Aigbogun MS, Guerin A, et al. The economic burden of schizophrenia in the United States in 2013. *J Clin Psychiatry*. 2016;77(6):764-771. doi:10.4088/JCP.15m10278

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