Opinion

LETTER

Soaring Drug Prices

MAY 11, 2015

To the Editor:

Re "Runaway Drug Prices" (editorial, May 5):

You are right to be alarmed by the skyrocketing costs of certain therapies. The blunt instrument of government price negotiations called for in the editorial, however, may be neither necessary nor wise.

Regulated prices can simply cause cost-shifting to other consumers. For example, best-price mandates in Medicaid's prescription drug rebate program led some manufacturers to recoup lost profits by charging more to consumers in private markets.

By contrast, the Medicare Part D prescription drug program's private-market approach to drug price negotiations has been widely hailed as a success. The program has come in significantly under its projected budget, and surveys of beneficiaries show high levels of satisfaction. Another private market force that will lower costs is the imminent arrival in the United States of biosimilar versions of expensive biologics.

Your prescription is an overreaction to recent price escalations. It's best for Congress and states to give proven practices used by Medicare Part D and in the private marketplace, as well as new drug discoveries, a chance to stem the tide of high prices.

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The Opinion Pages |New York Times Editorial

Runaway Drug Prices

By THE EDITORIAL BOARD MAY 5, 2015

A drug to treat abnormal heart rhythms can cost about $200 on one day and more than $1,300 the next. A diagnosis of multiple sclerosis can lead to a drug bill of at least $50,000 a year. How companies set prices of specialty drugs for these and other complex diseases, like cancer and AIDS, has been a mystery to the patients who need them. Now the Obama administration and some states are tackling that lack of transparency and the rising costs.

Mr. Obama has asked Congress to let Medicare officials negotiate prices with drug manufacturers, a practice forbidden by current law that may be hard to change with the antiregulatory mood among Republicans. And several states are considering bills that would require drug companies to justify their prices to public agencies. It is the least the states can do to bring costs to levels that patients, hospitals and government programs can afford.

Spending on all prescription drugs, including commonly used medicines like antibiotics, accounts for a tenth of the nation's total health spending. Prices have been rising slowly in recent years mainly because many brand-name drugs lost protection and lower-cost generics were prescribed. But there are fewer patent expirations ahead. Specialized medicines already on the market carry huge price tags, as The Times reported recently, and strain the budgets of Medicare, Medicaid and consumers. The list price for a one-year's supply of Kalydeco to treat cystic fibrosis is $311,000. A standard course of treatment with Blincyto, a leukemia drug, is about $178,000.

Drugs used to treat multiple sclerosis are of particular concern. A recent study by researchers in Oregon found that first-generation drugs that came on the market in the 1990s ranged in price from $8,000 to $11,000 a year. Prices for those drugs rose even though new drugs entered the market, theoretically providing competition. One drug that first cost $8,700 now costs $62,400 a year.

There are no multiple sclerosis drugs available in the United States with a list price below $50,000 a year, the researchers say, which is two to three times more than the list prices in Canada, Australia or Britain.

The drug and biotech companies contend that high prices are justified to cover the large costs of bringing a drug to market and to compensate for the large number of drugs that fail in late stages of costly clinical trials. But it appears that many companies raise prices arbitrarily and charge what public and private insurers will pay.

A recent report in The Wall Street Journal described how Valeant Pharmaceuticals International, based in Canada, bought the rights to two lifesaving heart drugs on Feb. 10 and raised their prices the same day. The list price for a one-milliliter vial of Isuprel, used to treat abnormal heart rhythms, rose to $1,347 from $215. The price for a two-milliliter vial of Nitropress, for dangerously high blood pressure and acute heart failure, increased from to $806 from $258. The Journal cites similar increases for Ofirmev pain injections and Vimovo pain tablets after new companies acquired the rights.

Bills have been introduced in several states requiring drug makers to report profits and expenses for costly drugs or sometimes for all drugs, according to The Journal's pharmaceutical blog. Such disclosures might shame companies into restraining their price increases and provide state officials with information to determine what action to take.

The industry helped defeat such a bill in Oregon and is fighting to head off a bill in California that would impose new reporting requirements on makers of any prescription drug whose wholesale costs are $10,000 or more annually or per course of treatment. They would have to disclose the research, development, marketing and manufacturing costs, as well as the profits, attributable to the drug. The companies complain that some of these costs are hard to quantify and that compiling the data would be burdensome. But surely the public would benefit from increased transparency that might deter the worst abuses.