Rising Prescription Drug Costs Point to Drug Pricing Reform

By Samantha-Jane Harris [1]  
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On Sept. 21, news that Turing Pharmaceuticals raised the price of a 62-year-old drug by 4,000 percent overnight made headlines. The drug, Daraprim, is critical to the care of HIV and AIDS patients. The sharp rise in price from $18 to $750 per pill is part of the all-too-familiar trend of drug-price spiking in the United States and highlights concerns about the sustainability of health care.

According to Andy Chasin, policy director of Blue Shield of California, the core issue at hand is the need to establish a new pricing system that gets the right care in the hands of patients in a way that is sustainable for both taxpayers and employers. Chasin told state legislators who gathered in Washington, D.C. Sept. 21-23 for the CSG Medicaid Leadership Policy Academy that he has a hard time believing the market for drugs is truly competitive. Rather, he argued, the prescription drug market seems to be characterized by strikingly uncompetitive and even brash pricing behavior that needs balancing.

Brian Bruen, lead research scientist and lecturer at The George Washington University’s School of Public Health and Health Services, said that he has been, “appalled at some of the price increases, because in some cases there is clearly no obvious cause for drug price changes other than for profiteering.”

Very high research and development costs to pharmaceutical companies are necessary to meet the demand for innovative drugs to fight diseases. Leslie Wood, deputy vice president of state policy at PhRMA, said that pharmaceutical companies spent about $50 billion dollars last year on research and development, which is more than any other sector in America. Wood urged legislators to consider the value of drugs to the patient and to the entire health care system when looking at the price tag.

And the value of drugs may vary significantly from medication to medication. Specialty drugs are more expensive but offer larger health benefits than traditional drugs, according to James D. Chambers, assistant professor at the Center for the Evaluation of Value and Risk Institute for Clinical Research and Health Policy Studies at Tufts Medical Center.

“This does not mean that all specialty drugs are good value for money,” Chambers said. “But what this does mean is that those drugs that offer the largest health benefits tend to be specialty drugs, and in many cases offer reasonable value for money.”

Incentives need to be aligned and reimbursements need to be higher for more effective treatments, Chambers said.

“We currently live in a paradox where treatments we all want to be developed are treatments we cannot afford because the system is broken.”
As part of the solution, Chambers suggested giving incentives to pharmaceutical companies to develop treatments with the understanding that those treatments will be used to help consumers live longer, better lives.

Indiana state Rep. Ed Clere, who co-chairs CSG’s Health Public Policy Committee, noted that we may have created an upside down system with a lack of incentive due to low generic drug costs.

“Rather than talking about ceilings on one side, which is an appropriate conversation,” Clere said, “we should also be talking about placing some floors to incentivize competition and development.”

Chasin agreed with Wood and Chambers that the system needs to be driving toward higher value and noted that Blue Shield has had success in reducing costs and improving quality through partnerships with hospitals and physician groups. He recommended that the pharmaceutical industry be more transparent about how new drugs compare to old drugs, and how drug prices are established.

States want transparency about drug costs. California, for instance, is working toward passing a transparency bill that calls for companies to be transparent about price increases. Opponents argue, however, that this would eliminate competition in the market and reduce incentives for development.

For some state leaders, the time for debate among insurers and the pharmaceutical industry is over. “We are tired of hearing what you should do and want to hear what you are going to do,” said Rep. Lloyd Larsen of Wyoming.

Some discussion on drug pricing reform in the United States points to a value-based drug pricing system. One challenge with adopting this system would be defining value. Bruen said, “Value-based pricing is a buzzword to some degree. We want to pay for value but there is a real challenge with defining it and from whose perspective.”

The new system would require clearly defined, quality economic measures. Entities such as the Institute for Clinical and Economic Review have launched programs to assess value, cost and budget impact to increase transparency in the drug pricing system.

Rep. Drew Gattine of Maine said, “We ought to be fundamentally paying for drugs differently. We need to make a determination as to what we think is a fair price and sit across the table and have an arms-length conversation about what is right and what is fair.”

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