Hyperinflation for some heavily used medications

Soaring Drug Costs Bite at Hospital’s Bottom Line

By Tyler Smith

With the new fiscal year just around the corner, University of Colorado Hospital is facing an unanticipated and significant expense: millions of additional dollars in drug expenses.

The budget for fiscal year 2016 (which begins July 1) originally projected 4 percent inflation for drug costs, said Chief Financial Officer Barbara Carveth. But massive increases in the prices the hospital pays for drugs, many of them heavily used, has pushed that projection to 6 percent. That translates to an additional $2.7 million in expenses, Carveth said.

“We started off using 4 percent in our budget assumptions, but realized that number would be insufficient because of these situations,” she said.

“These situations” include staggering price hikes for drugs UCH and other hospitals have used for many years. The increases aren’t the result of improvements in efficacy but rather business decisions made by pharmaceutical companies whose shareholders demand larger returns on their investments.

Nancy Stolpman, PharmD, PhD, has another term for it. “It’s price-gouging,” she said.

To the moon. As examples, Stolpman pointed to three drugs, nitroprusside, isoproterenol, and vasopressin, whose skyrocketing prices have played havoc with the hospital’s budget. The cost of nitroprusside, which lowers blood pressure, has jumped from $206 a vial to $683. Isoproterenol, once $43 a vial, now costs $1,226 for the same amount of the cardiac medication, Stolpman said. Both are generics with just one manufacturer. Vasopressin, an antidiuretic used for a variety of purposes, went from $1.60 to $42 a dose, the increase occurring after manufacturer American Regent discontinued production for a time early this year because of manufacturing delays.

The hikes for those three drugs alone cost the hospital more than $2 million, said Stolpman, who rattled off a number of other drugs whose costs have undergone double- and triple-digit inflation, from dextrose (58 percent) to epinephrine, an important agent for resuscitating patients (315 percent).

“These are all core drugs that we use in the hospital every day,” Stolpman said. “It’s 100 percent added expense to the hospital.” The price increases are “a classic case of why we can’t do business the same way,” she added. “Our reimbursement is going down while our expenses are going up. We don’t get enough from payers in many cases to cover the costs. Our margin is negative.”

Pressure points. There is no single reason for the increases, but in many cases they trace to steady or increasing demand for shrinking supplies, Stolpman said. Generic manufacturers have thin profit margins, which has driven some from the market. Others have been acquired by larger companies who then limit or eliminate competition and set prices higher.

Continued
In another scenario, one company buys rights to a drug from another and pays for the acquisition with heavy price increases. For example, the $43-per-vial cost of isoproterenol went to $218 after Marathon Pharmaceuticals bought the drug from Hospira. Earlier this year, Marathon sold the drug to Valeant Pharmaceuticals International, which jacked the price more than fivefold, to the present $1,226.

Specialty pharmaceuticals are another important factor in price inflation. Some that have produced important clinical breakthroughs come with impressive price tags to match. For example, the hepatitis C treatment Sovaldi came to market last year at the controversial price of $1,000 per pill, or $84,000 for a full treatment regimen. Many cancer drugs cost in excess of $100,000 a year.

“These drugs provide the best treatment options for patients, but they come at a high cost,” Carveth said.

**Distribution dilemma.** But it can at least be argued that these specialty drugs provide new clinical benefits for patients. The hospital late last year was at the receiving end of a large price increase for the cancer drugs bevacizumab, trastuzumab, and rituximab that had nothing to do with improving patient care.

The hospital abruptly received notice from the drug’s manufacturer, Genentech, that it would no longer sell the drugs through its regular wholesale distributor but would instead sell it through its specialty pharmaceutical distributor. The manufacturer also eliminated the drug discounts the hospital had negotiated, in effect increasing the price roughly $850,000, Stolpman said.

In a strongly worded letter to Genentech, UCHC President and CEO Liz Concordia, Chief Medical Officer Bill Neff, MD, and University of Colorado Cancer Center System Director of Oncology Services Tom Purcell, MD, protested the decision, noting that Genentech made a unilateral decision that would saddle the hospital and its patients with extra costs needlessly and complicate distribution of the drugs. They charged the decision was made solely to improve Genentech’s bottom line.

Rituximab (brand name Rituxan), a drug used to treat non-Hodgkin’s lymphoma, chronic lymphocytic leukemia, and rheumatoid arthritis, also has shown promise in slowing the progression of multiple sclerosis (MS) in some patients. John Corboy, MD, co-director of the Rocky Mountain MS Center at the Anschutz Medical Campus and professor of neurology with the CU School of Medicine, labeled the rituximab price hike “completely artificial.” He pointed to a broader pattern of price inflation for MS drugs.

Corboy noted an April 2015 study showing that first-generation disease-modifying therapies (DMTs) for MS that cost $8,000 to $11,000 when they entered the market starting 20 years ago now cost upwards of $60,000 a year — an inflation rate far higher than that of the overall prescription drug market. Newer DMTs for MS drugs, the study concluded, come on the market at a price 25 percent to 60 percent higher than the older drugs. The authors also pointed out that prices in Canada and Europe for the same drugs are far lower.

The cost of a vial of isoproterenol jumped more than five times recently.

In an email, Corboy attributed the disparity to the inability or unwillingness of the U.S. government to negotiate drug prices with manufacturers as its Canadian and European counterparts do. “This is a major political and regulatory failure on the part of our elected officials,” he wrote.

Jeff Thompson, director of government and corporate relations for UCHC, said “highly publicized drug shortages” periodically bring demands from some in Congress for price controls, but they’ve been short-lived.

“Historically legislation (threatened or actually introduced) to impose drug price controls eventually loses traction and doesn’t get too far,” Thompson said in an email, noting the power of the pharmaceutical lobby to thwart such efforts.
Searching for solutions. Without commenting on the advisability of price controls, Stolpman said standard free-market economics don’t apply to pharmaceutical pricing. In many business sectors, a 500 percent increase in a product would encourage competitors to produce lower-priced alternatives. But Stolpman said it will typically take a manufacturer three years to meet all FDA regulations to produce pharmaceuticals — and that’s with a plant and manufacturing facilities in place.

“That’s why we’re not seeing anyone new entering the market,” she said.

In the meantime, Stolpman said the hospital looks for ways to manage costs — shortening treatment durations; moving from intravenous to oral medications, as it did recently with acetaminophen; minimizing utilization when it’s safe to do so; and reducing waste. She cited the example of ribavirin, a treatment for infection. After the price increased from a little over $7,500 a vial to more than $10,000, Pharmacy stopped dispensing the entire vial and now doses it into three syringes instead, Stolpman said.

“We should manage waste on a day-to-day basis and evaluate our clinical options,” Carveth said, noting the Pharmacy & Therapeutics Committee routinely works with physicians to find clinically comparable alternatives to high-priced drugs. The hospital’s Medication Access and Renewal Center (MARC), launched last year, also works to manage the costs of specialty pharmaceuticals.

But there are limits to what the hospital can do, Carveth conceded. “When there aren’t good alternatives, we’re held hostage to the drug companies,” she said.