| | More from Globe OpinionSubmit a Letter to the EditorMeet the Editorial Board

OPINION

Drug prices in US are too high. Here's how to lower them.

The gap between US drug prices and those abroad is not a market outcome — it is the result of deliberate political and regulatory choices.

By **Ashish K. Jha and Irene Papanicolas** Updated May 18, 2026, 3:00 a.m.

There is a problem with drug costs that negotiation and competition alone don't fully solve. RICHARD MIA FOR THE BOSTON GLOBE

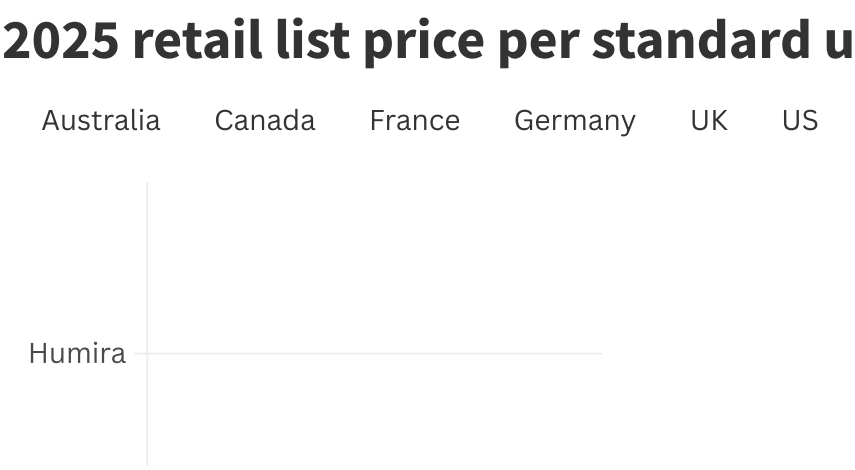
Dr. Ashish K. Jha is a senior fellow at the Belfer Center at Harvard Kennedy School and a contributing Globe Opinion writer. Irene Papanicolas is a professor of health services policy and practice at the Brown School of Public Health.

Consider two patients with the same cancer diagnosis. They are prescribed the same drug — Keytruda, the world's best-selling cancer medicine. One patient lives in Boston; the other in London. They don't know it, but this changes everything.

The London patient pays nothing to their doctor — the National Health Service negotiates the price and covers the bill. The Boston patient, who is on Medicare, meanwhile, may pay up to $2,100 out of pocket every three weeks with no supplemental coverage. There is no annual cap.

This is because, in the United States, until recently it's been illegal for Medicare to negotiate drug prices, and manufacturers can charge whatever they like without any justification.

Most other wealthy nations have made different choices. In the case of these two sick patients, the results speak for themselves.



Few sectors have done more to improve human health than the pharmaceutical industry. Drugs for HIV turned a death sentence into a manageable condition. Statins transformed cardiovascular disease. Immunotherapies and GLP-1s are reshaping care for cancer, obesity, and diabetes. Some of that foundational science was publicly funded, but the

costly work of turning basic research into medicines is overwhelmingly private, and it deserves to be rewarded.

The current system does reward genuine breakthroughs. GLP-1s have generated tens of billions of dollars for their manufacturers. But it rewards patent gaming and copycat drugs just as generously. A company that stacks secondary patents to extend a monopoly by a decade earns the same protection as one that develops a genuinely transformative medicine. AbbVie, for instance, filed more than 130 patents on Humira, covering things such as the injector button and known dosages, and keeping cheaper biosimilars off the US market for several years after its core patent expired, while charging roughly $72,000 per year. That is the problem. Good policy should preserve strong incentives for real innovation — not game a system that passes the costs to patients and taxpayers.

The Trump administration correctly diagnosed that Americans pay two to three times what peer nations pay for the same drugs. But its "most favored nation" initiative, which would bring US drug prices in line with prices paid in comparable countries, hasn't moved the needle. Drug companies keep raising prices, and 2025 had the highest number of brand-name drug list price increases ever recorded.

What has worked is Medicare drug price negotiation, established by the Inflation Reduction Act under the Biden administration and continued by the current one. The first round of 10 negotiated drugs produced price cuts of 38 to 79 percent and an estimated $6 billion in annual Medicare savings. Innovation didn't stop. That is where serious reform starts.

Negotiate — and mean it

The Inflation Reduction Act proved the concept. When Medicare negotiates, prices come down — and the pharmaceutical industry survives. Critics worried that it would crush innovation. The first round of negotiations, completed in 2024 and capped at 10 drugs, gave a real-world test: All 10 manufacturers agreed to negotiate, prices fell, Medicare

saved billions, and a rigorous analysis found the collective innovation impact amounted to less than one drug never being developed. The sky did not fall.

The problem is that the program is too narrow and too slow. Keytruda, the single-largest drug expenditure in Medicare, with $4.8 billion in allowed claims in 2023, cannot be negotiated until 2028 at the earliest. The 2025 budget legislation expanded the orphan drug exclusion, which shields drugs developed for rare diseases from price negotiation. While this carve-out makes sense in theory, it has been expanded to delay negotiation of Keytruda itself, a drug approved for 41 conditions, including some of the most common cancers in America. This narrows the program further at precisely the moment it should be growing. Meanwhile, a second round of 15 drugs will save an estimated $12 billion annually starting in 2027. The direction is right. The pace is not. Medicare is the largest drug buyer in the world. It should negotiate like it is — on more drugs, faster timelines, and with fewer loopholes.

When competition is permitted to work, it works. Stelara, a blockbuster immunotherapy, was one of the first drugs whose price was negotiated by Medicare. Then biosimilar competitors arrived and drove prices down by 90 percent, more than government negotiation had achieved. That is what markets do when they function. The problem is that ours largely don't.

Pharmaceutical manufacturers game the patent system to extend monopolies well beyond what Congress intended. Drug manufacturer AbbVie built a wall of more than 130 patents around Humira — most of them having nothing to do with the underlying medicine. The result was that competition was delayed, and American patients paid accordingly.

Only 10 percent of biologics losing patent protection in the next decade have a biosimilar in development. Reforming patent abuse, accelerating biosimilar approval, and fixing the perverse incentives that lead pharmacy benefit managers to favor high-list branded drugs over cheaper alternatives would unleash competition the system is

currently suppressing. Congress took a step in the right direction last year, but implementation is what matters now.

Lowering the cost of developing drugs matters, too. Clinical trials are extraordinarily expensive, and a meaningful share of that cost reflects regulatory requirements that have grown more burdensome without necessarily improving patient outcomes. The Food and Drug Administration could push for smarter trial design, adaptive approval pathways, and greater use of real-world evidence that could bring development costs down without compromising safety. Lower development costs also mean drugs don't need to be as expensive to justify the investment.

We already know what drugs cost

There is a deeper problem that negotiation and competition alone don't fully solve. Manufacturers set launch prices unilaterally, with no requirement to demonstrate that a new drug works better than what already exists, or that its price reflects its benefit. The Food and Drug Administration asks whether a drug is safe and effective. It does not ask whether a $200,000-a-year drug is worth $200,000 a year.

Many wealthy nations have some version of that question built into their systems, including the US. It has the Institute for Clinical and Economic Review, or ICER, an independent, privately funded agency that rigorously analyzes whether drug prices are justified by clinical benefit. Its work is credible and widely respected. It is also entirely advisory. No payer is required to consider it. Giving ICER's analyses real weight in Medicare's negotiating positions — not as a trigger for coverage denials, but as an anchor for what we are willing to pay — would help close the gap between what drugs cost and what they do for patients.

Expanding negotiation, fixing the patent system, and requiring that price reflect value at launch would not eliminate pharmaceutical innovation — they would redirect it toward the patients it is supposed to serve. The National Health Service in England pays half for

the same drug as in the United States because their system decided the price had to be justified. Ours never asked.

Show 20 comments