February 19, 2014

Well, they've done it again. A few hours ago, the pharmaceutical industry released another "study" which says that returning pseudoephedrine (PSE) to a prescription drug doesn't reduce meth labs, and will have huge economic costs. They paid for the study, of course. This time it's in West Virginia, where the West Virginia legislature is poised to pass a bill returning pseudoephedrine to a prescription drug. Here are my very quick responses to the new "study" – I'll use the "Highlights" directly from the study (which I've put in *blue italics*):

Section One Highlights

- *Oregon and Mississippi (states with prescription-only laws) and neighboring states (nonprescription-only states) experienced a decline in meth lab-related incidents over the same time periods.*

True, but misleading. For years, I've repeatedly tried to get the industry to stop using federal meth lab incident data to compare state-to-state. They know exactly why they shouldn't do that, but they persist. *See*: http://www.oregondec.org/MLIs-EPICvsReality-OR-WA.pdf

Here's the bigger point: Two years ago the industry paid for another "study." That time it was in Oregon. The 2012 study concluded, like this new study concludes, that returning PSE to a prescription drug didn't reduce meth lab incidents in Oregon. That flew in the face of the reality on the ground, of course, and last year the industry study was debunked by a thorough Government Accountability Office (GAO) study that reached two conclusions:

1. Returning PSE to a prescription drug reduces meth lab incidents; and
2. The industry's touted NPLEx system does not reduce meth lab incidents.

- *According to the Drug Enforcement Administration (DEA), nearly eighty percent of all meth sold in the U.S. is manufactured in Mexico and smuggled across the border by various drug cartels.*

That is true, but it's irrelevant. Returning PSE to a prescription drug has nothing to do with attacking the national and international meth problem. It has everything to do with attacking a state's domestic meth lab problem.

- *Since 2006, purchase restrictions on PSE-containing medication have been in effect in West Virginia. Meth-lab incidents decreased initially until 2007, spiked until 2010 and decreased again from 2010 until 2012.*

Why not talk about 2013, or thus far in 2014? Because meth lab incidents in West Virginia have spiked back up, despite NPLEx.

- *According to Trust for America's Health, West Virginia had the highest prescription-drug related, per capita death rate in the United States since 2011.*

Okay. The point seems to be that returning PSE to a prescription drug won't be effective, because prescription drugs are highly abused. But that misses the point. The domestic meth lab problem is fueled by the "smurfing" of PSE. Smurfing is where lots of people buy small legal amounts of PSE, and later it all gets to the meth "cooks." Returning PSE to a prescription drug eliminates smurfing. Entirely. For example, here is the actual experience in Oregon: Seven years after returning PSE to a prescription drug, there has not been a single meth lab incident in the Oregon where the source of the PSE was prescription PSE. It just hasn't happened.

Section Two Highlights

- *If the West Virginia General Assembly passed a prescription requirement, the number of doctor's office visits for upper respiratory infections is estimated to increase by 78,817 annually.*
- *The proposed legislation could cost $1.83 million to uninsured West Virginians.*
- *The annual direct cost to households in West Virginia is estimated to be slightly more than $3.7 million in West Virginia.*
- *The proposed prescription-only legislation is estimated to impose an additional burden of $8.3 million a year through lost productivity in the following forms: time spent for doctor's office visits and inability to have immediate access to medication for adults and children.*
- *Foregone sales tax revenue is calculated to be $321,309 annually in West Virginia.*
- *Over a 10-year period, the total cost of this policy change is expected to be $247.6 million.*

I'll combine my response to all of these together, since they all make the same error. First, nothing like that happened in Oregon or Mississippi.[1] Why? Whether they realize it or not, most people don't even use PSE. At all. Most people looking for relief from a cold simply buy what's on the store shelves. PSE hasn't been on store shelves anywhere in the United States since 2006. Furthermore, in Oregon and Mississippi, PSE was made a Schedule III controlled substance. The West Virginia legislation would make PSE a Schedule IV controlled substance. An office visit is not required for a physician to prescribe a Schedule III or IV drug to a regular patient, for those few remaining people who really want a PSE product. On top of all that, the West Virginia legislation would exempt the new tamper-resistant PSE products, which are available without a prescription. This financial impact estimate is disconnected from reality, which should come as no surprise, since it was paid for by the pharmaceutical industry to protect their profits from smurfed PSE.

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For more information on this topic, please see: http://www.oregondec.org/pse.htm

[1] By the way, the cost of returning PSE to a prescription drug for the entire Oregon Medicaid system is less than $8,000 a year. http://www.oregondec.org/CSPSC/012b-DHS.pdf