April 14, 2023

The Honorable Chiquita Brooks-LaSure, Administrator  
Centers for Medicare & Medicaid Services  
Hubert H. Humphrey Building Room 445-G  
200 Independence Ave, SW  
Washington, DC  20201  
Delivered electronically via: IRARebateandNegotiation@cms.hhs.gov

Re: Medicare Drug Price Negotiation Program Guidance

Dear Administrator Brooks-LaSure,

Thank you for the opportunity to comment on the “Medicare Drug Price Negotiation Program: Initial Memorandum, Implementation of Sections 1191-1198 of the Social Security Act for Initial Price Applicability Year 2026.”

I am writing on behalf of No Patient Left Behind (NPLB), a non-profit organization comprised of biotech investors, innovators, researchers, physicians, and patient advocates dedicated to three guiding principles: 1) prescribed treatments authorized by an insurer should be affordable to patients through zero or low out-of-pocket costs; 2) drug prices should not stay high for too long; and 3) sufficient R&D incentives must remain in place to ensure continued U.S. biotech innovation.

NPLB believes CMS can improve the Inflation Reduction Act (IRA) on behalf of patients, innovators, payors, and society with three proposed modifications. I also hope you review the more detailed supplemental comments at the end of this letter to assist CMS’ successful implementation of the new law.

Recommendations to improve IRA:

1) **Small molecule parity.** We urge the administration to work to limit IRA’s harmful impact on new small molecule R&D by initiating negotiation of New Drug Application (NDA) path therapies 13 years after Food and Drug Administration (FDA) approval. NPLB’s presentation, “How IRA makes new small molecule R&D uninvestable”, lays out in detail with specific examples from development stage biotech CEOs and patient advocates of how IRA’s penalty against new drug application treatments vs. biologics license application treatments (NDAs vs. BLAs) will result in fewer new therapies, particularly a meaningful reduction in oncology treatments. By prioritizing R&D in physician-administered shots over self-administered pills, IRA also will result in higher costs to patients, employers, and the federal government, which likely will miss out on significant future savings and lower out-of-pocket costs achieved through the proven market competition and reliable interchangeability of abbreviated new drug application (ANDA) “generic” therapies. For Medicare beneficiaries, the IRA incentivizing BLAs over NDAs also means that many future therapies will be covered by Medicare Part B that lacks IRA’s new $2000 annual catastrophic out-of-pocket cost limit.

2) **Incorporate Generalized Cost-effectiveness Analysis (GCEA) Methodologies.** When determining the value of an innovative medicine during the price-setting process, CMS should not rely on faulty and outdated math used by foreign governments, the Institute for Clinical and Economic Review (ICER), and vertically integrated U.S. health plans. These entities use traditional CEA math to deny patients access to innovative medicines via lack of coverage or unreasonably high out-of-pocket costs that health economists know deter patient access to prescribed treatments. Traditional CEA models purposefully omit real-world values of medicine impactful to patients, their families, and society. For example, ICER’s faulty and outdated math does not include simple,
demonstrable values, and basic facts, such as that medicines go generic, the likelihood of therapeutic competition, population changes, that caregivers and spouses are liberated and increase productivity when a patient gets better, and that medicines reduce risk for everyone worried about getting sick, incapacitated, or killed by a horrible condition. Furthermore, ICER’s outdated methodology stubbornly relies on a 3% discount rate when even the U.S. Office of Management & Budget is proposing economists use a 1.7% discount rate to determine the future value of innovations.

Please take the time to consider incorporating elements from this updated value “flower” in your health technology assessment calculations. It highlights which limited factors traditional CEAs use, the calculable values that updated CEAs could easily take into account today, and what additional values stakeholders should consider using in the future. The differentiation between traditional CEA and updated GCEA math also is explained via this brief animation.

3) **Low or no beneficiary cost-sharing for government negotiated drugs:** It is vital that CMS implements the law so that beneficiaries, not vertically integrated health plans and their sister organizations, benefit from a government price negotiation process that effectively transforms patent protected therapies into functionally generic government price set commodities. CMS has both the legislative requirement and strategic expertise in the negotiation process to require Medicare Advantage (MA), MA-PD plans, and Pharmacy Benefit Managers (PBMs) that take advantage of government negotiated prices to meaningfully lower both Part D and Part B beneficiaries’ out-of-pocket costs.

Requiring government “negotiated” savings be passed on to beneficiaries in the form of low or no out-of-pocket costs similar to how plans treat generic therapies is necessary to maximize the IRA’s benefits to Part D beneficiaries. For example, the Kaiser Family Foundation reported that “most Part D enrollees pay less than $10 for generic drugs, but many pay $40-$100 (or coinsurance of 40%-50%) for brand-name drugs.” The IRA will not fulfill both its legislative requirement and intended impact unless CMS contractually assures manufacturers and requires MA plans to similarly limit beneficiary out-of-pocket costs to less than $10 at Tier 1 copayments for all government negotiated drugs.

Similarly for Part B, while there is a 20% coinsurance limit per service, beneficiaries lack a catastrophic out-of-pocket cost cap. CMS should contractually require purchasers of Part B services that benefit from IRA’s new government negotiation process to charge no coinsurance or copayments in order to ensure that beneficiaries see commensurate out-of-pocket savings due to government intervention and price-setting.

Regarding health plan prior authorization requirements, we appreciate CMS’ recent efforts to end some of the unethical ways health plans have recently begun to use prior authorization to arbitrarily deny care and make it administratively burdensome for sick patients to access covered prescribed therapies at an affordable cost. Once again, NPLB recommends CMS requires plans use an expedited prior authorization process or prohibit prior authorization altogether for generic and government negotiated drugs.
In conclusion, NPLB supports IRA’s intent to achieve biotech affordability and innovation. We believe CMS and the Administration have an opportunity to help improve IRA so that it 1) treats all innovative therapies fairly at 13 years after FDA approval, 2) improves and updates traditional CEA methodology to help determine a medicine’s true value, and 3) requires MA plans to actually reduce beneficiary out-of-pocket costs for government negotiated drugs equivalent to a plan’s existing lowest-tier generic drug copayment.

Sincerely,

Peter Rubin
Executive Director
No Patient Left Behind (NPLB)
prubin@nopatientleftbehind.org

Supplemental Guidance Comments

<table>
<thead>
<tr>
<th>Provision</th>
<th>Concern</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>(30.1) Medicare negotiation for NDA-path drugs at nine-years post-launch.</td>
<td>Erosion of the R&amp;D case for all NDA-path drugs (small molecules, peptides, oligos, etc.) for diseases of aging. See NPLB’s open letter from leading biotech investors and innovators for a better understanding of how IRA makes new small molecule R&amp;D uninvestable.</td>
<td>CMS should seek parity for NDA-path and BLA-path drugs by initiating government price “negotiation” 13 years after FDA approval. NPLB supports CMS seeking a larger minimum discount as necessary to ensure budget neutrality resulting from an NDA negotiation timing change.</td>
</tr>
<tr>
<td>(30.1.1) Orphan drug “exclusion” for only one indication.</td>
<td>Drugs approved for a second orphan indication under a separate ODD will be subject to negotiation. This prevents</td>
<td>The harms from IRA’s treatment of orphan drugs could be mostly alleviated by creating small- and large-molecule parity for</td>
</tr>
</tbody>
</table>
companies from trying to treat multiple orphan diseases and hampers orphan drug development. This article illustrates how IRA already is reducing orphan drug R&D for patients whose indications have unmet medical needs.

This article illustrates how IRA already is reducing orphan drug R&D for patients whose indications have unmet medical needs.

This article illustrates how IRA already is reducing orphan drug R&D for patients whose indications have unmet medical needs.

This article illustrates how IRA already is reducing orphan drug R&D for patients whose indications have unmet medical needs.

This article illustrates how IRA already is reducing orphan drug R&D for patients whose indications have unmet medical needs.

This article illustrates how IRA already is reducing orphan drug R&D for patients whose indications have unmet medical needs.

This article illustrates how IRA already is reducing orphan drug R&D for patients whose indications have unmet medical needs.

This article illustrates how IRA already is reducing orphan drug R&D for patients whose indications have unmet medical needs.

This article illustrates how IRA already is reducing orphan drug R&D for patients whose indications have unmet medical needs.

This article illustrates how IRA already is reducing orphan drug R&D for patients whose indications have unmet medical needs.

This article illustrates how IRA already is reducing orphan drug R&D for patients whose indications have unmet medical needs.

This article illustrates how IRA already is reducing orphan drug R&D for patients whose indications have unmet medical needs.

This article illustrates how IRA already is reducing orphan drug R&D for patients whose indications have unmet medical needs.

This article illustrates how IRA already is reducing orphan drug R&D for patients whose indications have unmet medical needs.

This article illustrates how IRA already is reducing orphan drug R&D for patients whose indications have unmet medical needs.
active moiety to determine eligibility for negotiation. invalidate the new formulation’s orphan exemption, deterring investment in its development. However, the presence of the generics could also serve as a basis for the moiety in all its forms (including the new formulation) to not be selected for negotiation, which investors would find reassuring for their funding of the new formulation. In practical contradiction, CMS’ guidance suggests it may apply its arbitrary standard to determine that the original generic is not “bona fide” competition, thus making the new drug eligible for Medicare price negotiation at nine years, thereby deterring investment in its development.

reported by the manufacturer to the Medicaid Drug Rebate Program. It is defined as the date on which the drug is first sold in the US, and is the standard that CMS is using to determine whether a drug is marketed for purposes of the MDRP, the Part D inflation rebate guidance, and ASP (where the standard is articulated slightly different as the “first sale date.”

Other sections

<table>
<thead>
<tr>
<th>Provision</th>
<th>Concern</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>(50.2) CMS’ processes for determining the Maximum Fair Price for individual medicines as well as the relevance of “therapeutic alternatives” to the drugs it selects for negotiation.</td>
<td>Cost-effectiveness math embraced by ICER in the US and other HTA bodies elsewhere (e.g., NICE in the UK) is so simplified that it excludes many demonstrable benefits of medicines (e.g., they liberate caregivers, they reduce risk for healthy people, they go generic yet keep on working), resulting in extreme under-estimations of the value of new medicines. This math can then serve as an excuse for plans to refuse coverage, essentially telling patients that the medicines aren’t worth their prices instead of admitting that the plan just doesn’t want to cover or reimburse for the prescribed</td>
<td>To the extent that CMS wants to appreciate the value that a medicine brings to society before it decides how aggressively to set its price (particularly in the case of NDA-path drugs that experience negotiation far sooner than would have gone generic), CMS should broadly account for a medicine’s value elements, using a dynamic stacked cohort model that accounts for value to patients, to caregivers, and to the rest of the population whose risk is reduced by having the drug (i.e., if it’s going to do CEA, do generalized CEA, not conventional over-simplified CEA).</td>
</tr>
</tbody>
</table>
Considering that drugs can go generic and keep us out of hospitals and nursing homes, which do not go generic. ICER-like over-simplified CEA math that undervalues drugs would signal to investors and innovators that the value of new medicines will be willfully underestimated to justify not rewarding their development, which will turn investors away from funding future biomedical R&D.

<table>
<thead>
<tr>
<th>Provision</th>
<th>Concern</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>(90.4) For the purposes of determining if a drug can be selected (or should still be subject to negotiation once selected), CMS will look to whether there is an approved generic or biosimilar under 505(j) or 351(k), and also bona fide marketing/robust and meaningful competition of a generic or biosimilar brand.</td>
<td>CMS' broad discretion in determining what is &quot;bona fide competition&quot; suggests it favors the ability to determine drug price via its negotiation process rather than letting true competition play out in the marketplace.</td>
<td>The IRA threatens to make generic business models unsustainable for drugs that treat Medicare populations. One might think this does not matter because price reduction will be achieved via negotiation. However, because generic competition often drives costs down not only by eroding the gross margins of the original drug but also spurring manufacturing improvements that lower cost of goods, the IRA threatens to leave society paying more for old drugs in the long run by deterring generic competition.</td>
</tr>
<tr>
<td>CMS will categorize drugs by active moiety to determine eligibility for negotiation.</td>
<td>The &quot;bona fide&quot; generic competition standard will reduce the reward for first filer generics and hurt generic competition.</td>
<td>This could increase overall costs across market segments (Medicare and commercial payers).</td>
</tr>
<tr>
<td>Nowhere does the guidance specify what share or availability metrics may qualify as &quot;bona fide.&quot;</td>
<td>CMS is basically looking to the slowest adopters of generics (part D plans) to determine if competition is real.</td>
<td></td>
</tr>
</tbody>
</table>
(40.2.2) CMS prohibitions on data disclosure and destruction of related documents.

<table>
<thead>
<tr>
<th>The lack of transparency around the negotiation process makes it impossible for companies to understand which value components CMS is measuring in determining MFP.</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMS’s process for determining value and cost-effectiveness should be transparent (vs. gag order and document destruction that they propose today). It should be able to defend what it considers to be a “fair price.” Furthermore, this prohibition violates company First Amendment rights. Companies subject to the negotiation process need to be able to disclose to their boards and their investors what occurred in the negotiation process.</td>
</tr>
</tbody>
</table>