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**VIA Electronic Filing – *IRARebateandNegotiation@cms.hhs.gov***

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Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
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**Re: Medicare Drug Price Negotiation Program: Draft Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for the Initial Price Applicability Year 2027, and Manufacturer Effectuation of the Maximum Fair Price in 2026 and 2027**

Dear Deputy Administrator Seshamani:

The Pharmaceutical Research and Manufacturers of America (PhRMA) appreciates the opportunity to respond to the Centers for Medicare & Medicaid Services' (CMS, the Agency) *Medicare Drug Price Negotiation Program: Draft Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year 2027 and Manufacturer Effectuation of the Maximum Fair Price (MFP) in 2026 and 2027* (Guidance or the Guidance) which CMS released on May 3, 2024.[1] We represent the country's leading innovative biopharmaceutical research companies, which are devoted to discovering and developing medicines that enable patients to live longer, healthier, and more productive lives. Our sector is one of the most research-intensive industries in the United States: over the last decade, PhRMA member companies have more than doubled their annual investment in the search for new treatments and cures, including nearly $101 billion in 2022 alone.[2]

PhRMA has longstanding concerns about the impact of government price setting on patients. Our concern is grounded in the industry's substantial and longstanding experience with price setting policies in foreign countries, where patients go without or face significant delays before accessing many important treatments.[3] We are deeply concerned that Medicare beneficiaries could see parallel access disruptions resulting from the IRA's price setting provisions. Those provisions are also creating considerable uncertainty that will hamper development of life-changing treatments and cures.

To an extent, patient access and innovation will always be under threat as long as the price setting provisions of the IRA remain in place. This is true to an even *greater* extent if policymakers are successful in their rushed

[1] CMS. (May 3, 2024). Medicare Drug Price Negotiation Program: Draft Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year 2027 and Manufacturer Effectuation of the Maximum Fair Price (MFP) in 2026 and 2027. Available at: https://www.cms.gov/files/document/medicare-drug-price-negotiation-draft-guidance-ipay-2027-and-manufacturer-effectuation-mfp-2026-2027.pdf.
[2] PhRMA. (July 26, 2023). 2023 PhRMA Annual Membership Survey. Available at: https://phrma.org/resource-center/Topics/Research-and-Development/2023-PhRMA-Annual-Membership-Survey
[3] PhRMA. (April 12, 2023). New Global Analysis Shows Patient Access Challenges Around the World. Available at: https://phrma.org/Blog/New-global-analysis-shows-patient-access-challenges-around-the-world

attempts to *expand* the Medicare Drug Price Negotiation Program (Program) to include additional drugs or market segments only two years following enactment of the law.[4] However, as we emphasized in our comments on the Initial Guidance for IPAY 2026, CMS has an opportunity to promote transparency, accountability, and confidentiality in the Program's operation through implementation.

We are disappointed that after more than a year of hearing concerns and feedback from stakeholders, CMS has largely[5] stayed its course in the Guidance for IPAY 2027. In this letter, we articulate our core concerns with CMS' Draft Guidance for IPAY 2027, as follows:

I. CMS is not negotiating with manufacturers; it is setting drug prices in an arbitrary manner that is highly susceptible to politicization.

II. CMS' implementation of the Program puts patient access to medicines in Medicare Part D at risk.

III. CMS' implementation of the Program undermines competitive marketplace dynamics, which successfully drives patient access to new medicines and cost containment.

IV. CMS' implementation of the Program will do irreparable harm to innovation, to the detriment of patients.

V. CMS has failed to implement proper safeguards to protect patients and clinicians in its implementation of the Program.

Aside from outlining our core concerns with the Guidance, we are attaching to this letter several Appendices that provide technical, in-depth input on specific issues. In many instances, the consensus-based recommendations outlined in the Appendices are in addition to feedback that PhRMA has previously provided to CMS in other comment letters or forums. The topics they focus on are of great importance to PhRMA's membership, and we welcome the opportunity to discuss them in more detail with CMS staff.

Appendix A: Drug Selection;

Appendix B: Effectuation of the Maximum Fair Price; and

Appendix C: Strengthening Access and Formulary Protections in Medicare Part D.

Despite our aforementioned concerns regarding government price setting, in advance of IPAY 2026, PhRMA recognized CMS' statutory obligation to implement the Program. Thus, in response to Initial Guidance for IPAY 2026[6], PhRMA articulated concrete, actionable recommendations for CMS on implementation of the Program in issue areas that were open for comment. Unfortunately, CMS disregarded most of PhRMA's recommendations, as it did with most stakeholder feedback in advance of IPAY 2026.[7] We strongly recommend CMS revisit and adopt PhRMA's prior recommendations in implementing the Program for IPAY 2027. We have attached those prior recommendations as Appendix D.

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[4] The White House. (March 7, 2024). Remarks of President Joe Biden – State of the Union Address as Prepared for Delivery. Available at: https://www.whitehouse.gov/briefing-room/speeches-remarks/2024/03/07/remarks-of-president-joe-biden-state-of-the-union-address-as-prepared-for-delivery-2/

[5] We are disappointed that CMS has, on most issues, not changed course on its implementation of the Program. However, PhRMA appreciates the significant expansion of Agency guidance covering effectuation of the Maximum Fair Price (MFP), although we continue to have concerns that the process for Primary Manufacturers to provide access to the MFP, as proposed by the Agency, creates significant financial and operational burdens on manufacturers and other supply chain stakeholders. PhRMA offers technical comments on this portion of the Guidance in Appendix B (Effectuation of the Maximum Fair Price) of this letter.

[6] PhRMA. PhRMA Comments on CMS Initial Guidance on Medicare Drug Price Negotiation Program. (April 14, 2023). Available at: https://phrma.org/-/media/Project/PhRMA/PhRMA-Org/PhRMA-Org/PDF/G-I/PhRMA-Comments-on-CMS-Initial-Guidance-on-Medicare-Drug-Price-Negotiation-Program22948.pdf

[7] CMS also intentionally did not solicit comments on foundational aspects of the IPAY 2026 guidance, such as Section 30 (discussing QSSD and bona fide marketing).

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## I. CMS is not negotiating with manufacturers; it is setting drug prices in an arbitrary manner that is highly susceptible to politicization.

The IRA and CMS label government price setting as "negotiation." Indeed, CMS' Guidance used this term nearly 400 times. But simply repeating the word does not make it true. In reality, the IRA provides for highly limited exchanges between manufacturers of "selected drugs" and CMS. As noted by those with experience in the negotiations that occur between insurance companies and biopharmaceutical manufacturers in the private sector, the Program in no way resembles such negotiations, and should not be mistaken for such.[8] Put simply, CMS has the unilateral, nearly unconstrained authority to both set any price it wishes below a statutory ceiling and impose severe penalties on manufacturers who do not agree to the CMS-set price, with little-to-no transparency on how CMS reached this price in the first place.

Below, we outline the specific aspects of the IRA price setting framework, and CMS' implementation of the Program, supporting our assertion that it does not constitute "negotiation."

***"Negotiation" under the IRA does not in any way resemble negotiations that occur in the private market.***

*Manufacturer Penalties*

If a manufacturer fails to agree to the price CMS sets, the manufacturer faces either exclusion from entire market segments or severe financial penalties that would be impossible for any company to sustain. Under the IRA, if a manufacturer doesn't agree to "negotiate" or agrees to negotiate but doesn't agree to the CMS-set price, it must withdraw *all* of its products from the entirety of the approximately 45 percent of the nationwide retail prescription drug market comprised of Medicare and Medicaid spending.[9] Manufacturers' only alternative is to accept an excise tax of up to 1,900 percent and, in some circumstances, civil monetary penalties. Those are not potential outcomes in actual negotiations. These penalties are severe and disproportionate to other penalties imposed by Medicare; they are clearly intended to command compliance, rather than encourage true negotiation.[10]

Moreover, the government is empowered to impose significant fines, including a $1 million dollar per day penalty on manufacturers if they do not produce an extremely broad array of information, much of it proprietary, difficult to accumulate, and not relevant to setting a Medicare price. However, manufacturers have no equivalent authority to demand information of the government related to its analysis and decision making. CMS' authority to compel a manufacturer to produce data under threat of severe penalties is another of many signs that the Program does not represent actual negotiation.

*Ceiling Price*

The IRA price setting framework, unlike actual negotiation, includes a ceiling, or absolute cap on a medicine's price in Medicare based in part on the time since the medicine was approved by FDA. This ceiling is not subject to negotiation and cannot be exceeded for any reason, including factors such as the drug meeting an unmet medical need, its superiority over alternative treatments, or new uses that recently obtained FDA approval or that are under development through ongoing clinical trials. We are not aware of any bona fide, private market negotiations in which the purchaser starts with a ceiling price set externally and enforces its chosen price with harsh penalties.

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[8] Shah S. (June 20, 2024). Here are four reasons Medicare drug-price 'negotiation' in NJ isn't truly a negotiation. Courier Post. Available at: https://www.courierpostonline.com/story/opinion/2024/06/13/medicare-drug-price-negotiation-in-nj-isnt-truly-a-negotiation/73896264007/

[9] CBO. (January 2022). Prescription Drugs: Spending, Use, and Prices. Available at: https://www.cbo.gov/publication/57772

[10] In fact, the Congressional Budget Office score for the IRA presumes that the excise tax will not generate any revenue independent of its effects on Medicare drug pricing through imposition of the government's MFP. See Congressional Budget Office, Estimated Budgetary Effects of Public Law 117-169, to Provide for Reconciliation Pursuant to Title II of S. Con. Res. 14 at 5 (Sept. 7, 2022). Available at: https://www.cbo.gov/system/files/2022-09/PL117-169_9-7-22.pdf.

*Renegotiation*

Finally, the result of an IRA "negotiation" can always be reopened by one party – the Secretary – but not by manufacturers, and the statute purports to insulate renegotiations from administrative and judicial review. Under Section 1194(f) of the Social Security Act (SSA), the Secretary will "renegotiate" a previously set "negotiated" price whenever "the Secretary determines there has been a material change" in any of the clinical or manufacturer-specific factors.[11] To date, the Secretary has declined to provide direction regarding what would constitute a "material change," leading to uncertainty in the commercial stability of the prices the Secretary imposes when a manufacturer is first subject to an MFP, and leading to concerns that the Secretary may seek to upend these previously set prices at an unknown future time.[12]

*Other Elements*

Beyond the aforementioned issues, it is also notable that IRA "negotiation" has none of the hallmarks of actual negotiation over drug prices that occur in the commercial market. Based on our membership's vast experience in such negotiations (experience that CMS is notably lacking), there are numerous other examples of how the Program diametrically differs from true private market negotiation, including the following:

- **Access Tradeoffs.** In true negotiation, drug prices are balanced against patient access to the drug, including issues such as formulary tiering and utilization management; under the Program the price of a selected drug is set without reference to the terms of that drug's coverage, other than it must be offered by Part D plans. The parameters of access for selected drugs remain to be determined by Part D plans, which, in exchange for needing to cover the selected drug, receive the government-set price as a *starting point* for negotiations with manufacturers, without regard to how they cover the medicine.

- **Terms and Conditions.** In a true negotiation, the parties can offer revision, clarification, amendment, or customization of the non-price terms and conditions of a contract; under the Program, CMS publishes a "one size fits all" contract of adhesion that manufacturers must sign – and that agreement contains unilateral amendment authority for CMS, but not the manufacturer;[13]

- **Timing of Contract.** In a true negotiation, parties sign a contract after agreeing to a price term; under the Program, manufacturers must sign an agreement before CMS offers a final price;

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[11] Section 1194(f) provides for renegotiation in additional circumstances.

[12] CMS and the Department of Justice (DOJ) have stated, without further explanation, that manufacturers may simply cease selling their products to Medicare. For example, DOJ argues that there is no "mechanism to force manufacturers to actually make sales of any drug," and that "after signing the agreement with CMS, [a manufacturer]" could "refuse to transfer [a selected drug] to Medicare at all," and "that would not be prohibited by the IRA." *Bristol Myers Squibb Co. v. Becerra*, No. 23-cv-03335-ZNQ (D.N.J., Dec. 22, 2023), ECF No. 84 at 32. In the draft guidance, CMS states that a manufacturer "is not obligated to make sales of the selected drug." Draft Guidance at § 40.4. Both CMS and DOJ fail to acknowledge that manufacturers do not "transfer" drugs to Medicare – they typically sell drugs to wholesalers, who sell to a pharmacy or other dispenser. Medicare is a payer – it does not purchase an inventory of drugs directly from manufacturers (or wholesalers). Further, the manufacturer does not have knowledge of the insurance status of the patient when it sells its drugs. CMS presumably understands the pharmaceutical supply chain and yet continues to make and allow statements that willfully ignore it. At the very least, if CMS and DOJ believe that blocking sales or transfers of drugs "to Medicare" is an option, the Agency should explain the logistical and legal rationales for how manufacturers could cease selling selected drugs to Medicare beneficiaries "at all."
CMS and DOJ have also argued that CMS may read the Agency's authority to *involuntarily* terminate Part D agreements for a manufacturer's knowing or willful violation or other good cause as somehow equivalent to a manufacturer *voluntarily* withdrawing using the manufacturer's own authority. *Compare* clause (i) and clause (ii) of SSA §§ 1860D-14A(b)(4)(B) and 1860D-14C(b)(4)(B), respectively. However, CMS does not explain how its reading accords with the canon of statutory construction that a term must be understood in light of "the neighboring words with which it is associated," *United States v. Williams*, 553 U.S. 285, 294 (2008), or is anything more than pretext to paint the IRA program in the light most favorable to the Agency's litigation posture without regard to the plain language in the law.

[13] The agreement states: "CMS retains authority to amend this Agreement to reflect changes in . . . guidance. When possible, CMS shall give the Manufacturer at least 60-day notice of any change to the Agreement." Available at: https://www.cms.gov/files/document/inflation-reduction-act-manufacturer-agreement-template.pdf.

- **Legal Recourse.** In a true negotiation, either party may seek to redress any legal and equitable claims; under the Program, the statute purports to limit manufacturers from seeking any form of judicial or administrative review of fundamental Agency actions; and

- **Disclosure of Information.** In a true negotiation, parties may – but certainly are not required to – turn over any manufacturing or distribution costs, sales forecasts, marketing budgets, or other trade secrets or proprietary data demanded by the other party; under the Program, CMS requires the submission of extensive, highly-sensitive data in a truly burdensome manner.[14,15]

These issues are further compounded by the lack of transparency stakeholders, including manufacturers of selected drugs, have into the price setting process. This lack of transparency limits the ability of the manufacturer to produce data that will be impactful and help inform CMS decision making. As such, manufacturers of selected drugs have found interactions with CMS thus far to be lacking in the type of information sharing and dialogue that would accompany a true negotiation. CMS seeks feedback on whether CMS should conduct fewer meetings with manufacturers of selected drugs in IPAY 2027. Based on the IPAY 2026 experience, however, fewer meetings would only exacerbate the opacity of the price setting process for manufacturers. PhRMA strongly recommends that CMS meet with the same frequency with manufacturers as in IPAY 2026 but also provide insight into its thinking, processes and next steps so that manufacturers may appropriately engage.

***The IRA grants CMS broad price setting authority that is highly susceptible to politicization.***

*Lack of Transparent Methodology for Price Setting*

Instead of establishing the "consistent process and methodology" required by Section 1194 of the SSA, CMS has stated it will take a "qualitative approach" to setting and adjusting the starting price based on the "totality of the relevant information and evidence" about the medicine and the identified "therapeutic alternative(s)". That price will then be adjusted by an undefined amount based on one or more of the "manufacturer-specific" factors listed in SSA Section 1194(e)(1)[16], with the factors considered "in isolation or in combination with other factors."[17]

Unfortunately, CMS' Guidance does not provide any insight into:

- How the evidence CMS develops on its own and receives from manufacturers and the public will be converted into conclusions about the factors;

- How the factors will be weighted;

- How CMS will determine whether and by how much to adjust the price for the factors that "may" be used to adjust price, and whether to consider those factors singly or in combination; and

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[14] Internal feedback based on company survey of experience indicates that the information collection process was extraordinarily more burdensome than CMS estimated despite the extensive recommendations PhRMA provided to CMS on how to more productively facilitate collection. CMS not only requested information that was almost impossible to collect but also in a manner that significantly differed from corporate record-keeping.

[15] Of note, in the most recent Guidance outlined in "Appendix A (Definitions for Purposes of Collecting Manufacturer-Specific Data), CMS includes a new "Market Data and Revenue and Sales Volume Data" element on Manufacturer net Medicare Part D price. Specifically, CMS seeks to collect the "net Medicare Part D price as calculated by the Primary Manufacturer," and goes on to elaborate that the Agency seeks "specific data to which the manufacturer has access including coverage gap discounts and other supply chain concessions (e.g., wholesale discounts) not reflected in the sum of the plan-specific enrollment weighted amounts calculation, and utilization that may differ from the PDE data". This data element is concerning. If viewed as an attempt to aggregate price concessions from supply chain entities across the pharmaceutical supply chain, it would not represent an accurate assessment of net Medicare Part D price at the NDC-11 level. This is not only an inaccurate accumulation of discounts for CMS to require but represents significant burden upon Primary Manufacturers that would be required to track and aggregate, at the NDC-11 level, "supply chain concessions". The term also is overly broad, particularly the references to "other supply chain concessions" and "wholesale discounts" with little direction for accurate data collection.

[16] CMS. (June 30, 2023). Revised Medicare Drug Price Negotiation Program Guidance. Available at: https://www.cms.gov/files/document/revised-medicare-drug-price-negotiation-program-guidance-june-2023.pdf, Section 60.3.3.1, pg. 149.

[17] Ibid, Section 60.3.4, pp. 150-51.

- How the evidence and factors will be translated into a specific price.

This lack of clear, objective standards or any explanation of how these criteria will be used in price setting means CMS can specify any price below the ceiling and will likely always be able to conjure a justification. Without a transparent and predefined protocol for the Agency's evidence identification and review process., experts within CMS risk targeting the wrong sources, omitting important evidence, and increased subjectivity and bias in their review – making it difficult to replicate findings. In fact, the Guidance itself contains clear examples of CMS putting its thumb on the scale to achieve lower prices beyond the authority it is granted in statute.[18]

*Politicization of Price Setting*

Per the IRA, Maximum Fair Prices are set by Secretary of Health and Human Services, a political appointee, who is accorded broad decision-making authority and whose decisions are purportedly exempt from administrative and judicial review for the most consequential aspects of the Program. CMS has also argued that the Agency need not engage in notice-and-comment rulemaking to consider the views and expertise of stakeholders.

Regardless of the approach taken by the Secretary, there is a significant threat that either a current or future Secretary could make predominantly political decisions regarding prices of selected drugs. For instance, a Secretary may decide that political circumstances dictate that an election year is an optimal time to renegotiate by determining a "material change" has occurred. Or the Secretary could set excessively low prices to demonstrate that an Administration is lowering seniors' costs. Although not every Secretary may be so politically motivated, the unconstitutional legislative authority delegated by the IRA (as discussed below) means that there exists broad opportunity and incentives for setting prices on a political basis, and the Program contains *absolutely no safeguards against politically set prices*. CMS appears to have declined its responsibility to address this issue in the Guidance.[19]

*Unconstitutional Delegation of Authority*

Indeed, the price setting authority under the IRA is so overly broad that it amounts to an unconstitutional delegation of legislative authority. CMS has already taken advantage of that unconstrained delegation, going beyond the statute to impose its own definition of what is a "Qualifying Single Source Drug" (QSSD), and its own vague standard for whether a generic drug or biosimilar product is "marketed" such that a listed or reference drug cannot be selected for price setting. CMS also has arbitrarily offered conflicting interpretations of what entities qualify as a "manufacturer" subject to price setting—imposing vicarious responsibility and liability on primary manufacturers for the information and actions of unrelated corporate entities that the Agency deems "secondary manufacturers," while simultaneously asserting that only a subsidiary corporation listed on an FDA application (and not a parent entity) has standing to sue.[20] In these ways, CMS has quickly demonstrated how

[18] CMS also proposes in Section 60.3 of the Draft Guidance to use, in certain cases, the "Part D total gross covered drug cost (TGCDC) net of DIR and CGDP [coverage gap discount program] payments . . . for the therapeutic alternative(s)," as part of establishing the starting point for developing an initial offer for a selected drug. This proposal violates the intent of the IRA and must not be finalized. Nothing in the IRA reflects a Congressional intent for CMS to consider manufacturer or coverage gap discounts in price-setting. To the contrary, the statute specifically excludes selected drugs from the definition of "applicable drugs" subject to the manufacturer discount in Part D, the successor to the CGDP. SSA § 1860D-14C(g)(2)(B). Yet, CMS' proposal would circumvent this intent by using – as the comparative starting point for establishing an MFP – a price that reflects these discounts. Effectively, CMS would be reincorporating the discounts into the MFP, when Congress specifically required that manufacturers of selected drugs are exempt from such discounts. We further note that Congress instructed CMS, as part of price setting, to include in the ceiling price the Part D "price concessions" that are received by the plan or pharmacy benefit manager on behalf of the plan and constitute direct or indirect remuneration. SSA § 1194(c)(2)(A). Congress did not direct CMS to include estimated Part D manufacturer or coverage gap discounts as part of this calculation.

[19] Examples of actions CMS could take to limit political influence over price setting include establishing a consistent methodology for arriving at prices for selected drugs or establishing a robust dispute resolution process.

[20] *Merck v. Becerra*, Case No. 1:23-cv-01615 (D.D.C.), ECF No. 24 at 19-20 (arguing lack of standing due to a subsidiary holding the NDA for the selected drug); *Dayton Area Chamber of Comm. v. Becerra*, Case No. 3:23-cv-00156 (S.D.Ohio), ECF No. 71 at 13-14 (arguing that Pharmacyclics, a subsidiary of AbbVie, is the only entity harmed by price setting).

unconstrained it views its authority. Indeed, CMS has even told a federal court that it is empowered to misread statutory language that is "clear as a bell," without any opportunity for judicial review.[21]

## II. CMS' implementation of the Program puts patient access to medicines in Medicare Part D at risk.

In comments on CMS' Initial Guidance for IPAY 2026, many stakeholders raised concern that CMS price setting in Part D could disrupt patient access to care and result in barriers to needed medicines. The Agency acknowledged this in its IPAY 2026 Revised Guidance and repeated it again in the Draft Guidance for IPAY 2027, stating "… CMS is concerned that Part D sponsors may be incentivized in certain circumstances to disadvantage selected drugs by placing selected drugs on less favorable tiers compared to non-selected drugs, or by applying utilization management (UM) that is not based on medical appropriateness to steer Part D beneficiaries away from selected drugs in favor of non-selected drugs."[22]

CMS' concern is well-placed. Disadvantaging drugs means disadvantaging *patients* who will face more barriers to obtaining the medicine they need. To guard against the negative impacts of price setting, which are compounded by other provisions of the IRA related to Part D, it is critical that CMS maintain and improve upon existing statutory and regulatory formulary standards. Nondiscrimination and formulary standards are essential elements of Part D;[23] to the extent those standards were adequate prior to enactment of the IRA, they are no longer likely to remain adequate under pressure from the effects of the IRA. Our detailed recommendations for improvements to Part D formulary standards are provided in Appendix C (Strengthening Access and Formulary Protections in Medicare Part D).

***Medicare patients need timely access to a choice of medicines to ensure effective treatment of a range of serious diseases and conditions.***

Patients' access to medicines is central to our ability to effectively improve health and reduce downstream costs. For example, medicines have profoundly changed what it means for a patient to have and be treated for cardiovascular and cerebrovascular diseases, many cancers, diabetes, HIV/AIDS, and depression. Leading researchers have attributed 35 percent of the 3.3-year gain in life expectancy from 1990-2015 to pharmaceuticals, compared to 13 percent attributable to other medical care.[24]

However, to improve patient health outcomes with medicines, patients must have timely access to medicines. This involves ensuring individual patients have access to the range of medicines they may need to meet their specific needs and circumstances. As a result, it is important to ensure that formulary coverage, tiering and UM operate as tools for health plans to effectively negotiate with manufacturers and appropriately control costs, and *not as* barriers to obtaining the right medicine for a given patient. It is precisely because it is important for patients and

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[21] *AstraZeneca v. Becerra*, Case No. 1:23-cv-00931, Tr. Oral Argument at 99-100 (D. Del. Jan. 31, 2024) ("THE COURT: Let's say this is. I read the statute. It's clear as a bell . . . So let's just say I agree with AstraZeneca on that. When would a drug company be able to challenge your designation of its blockbuster product? Let's say it only makes one product. When can it do that? MR. NETTER: So it wouldn't be able to, Your Honor. THE COURT: Ever? MR. NETTER: Ever? Well, unless they could try to convince Congress to change the statutory bar. But it's Congress' prerogative. THE COURT: That doesn't bother you, that you could have -- again, imagine it was, again, that there was no other ambiguity in the statute to shed doubt on AstraZeneca's interpretation. So you're saying that an Agency can come along and can issue a regulation that absolutely contradicts the explicit statutory text of Congress? And here -- and you're saying, tough noogies, there's no review? MR. NETTER: That is the outcome of the standard analysis on judicial bars.").

[22] Section 110. Presumably CMS' concern is rooted in the possibility that Part D plans will prefer non-selected drugs with higher list prices and higher rebates to selected drugs with lower list prices.

[23] Certain Part D formulary standards were premised on the Medicare Modernization Act's nondiscrimination requirements at Section 1860D-11(e)(2)(D)(i). Research on Part D and other programs suggests formulary design can be used as a way to encourage or discourage enrollment by certain beneficiaries, https://www.nber.org/papers/w22338 and https://www.aeaweb.org/articles?id=10.1257/pol.20170014. This underscores the need for improved formulary standards and risk adjustment as existing standards are challenged by dramatic program design changes that could encourage new barriers to patient access to medicines.

[24] Buxbaum J.D., Chernew M.E., Fendrick A.M., Cutler D.M. (September 2020). Contributions of Public Health, Pharmaceuticals, and Other Medical Care to US Life Expectancy Changes, 1990-2015. Health Affairs. Available at: https://www.healthaffairs.org/doi/10.1377/hlthaff.2020.00284.

clinicians to have a choice of medicines that efforts by plans and PBMs to steer patients among drugs using strategies "not based on medical appropriateness" create cause for concern.

CMS' Guidance recognizes the fundamental principle that patients differ from one another, as do medicines, even when in the same therapeutic class. Because of differences in clinical circumstances and individual health needs and preferences, patients benefit from access to a range of treatment options, which has been repeatedly underscored by professional consensus and research.[25,26] Furthermore, a medicine's average effect will not always apply to all subsets of patients due to factors such as genetics, drug-drug interactions, age, and comorbidities.[27] For example, the American College of Rheumatology, notes that individual treatment decisions for rheumatoid arthritis patients should be made based on patients' values, goals, preferences, and comorbidities, citing 44 different recommendations.[28] As described in more detail below, the IRA is likely to exacerbate the trend of increasing formulary exclusions and coverage restrictions. Thus, it is vital for CMS to strengthen formulary standards and oversight to address this and protect beneficiary access to a range of treatment options in Part D.

***The IRA puts patient access to both selected medicines and non-selected medicines at risk.***

Since its inception, the Part D program has proved remarkably successful in providing Medicare beneficiaries access to a range of outpatient prescription medicines and keeping premiums low through a choice of competing health plans. Underscoring this success, beneficiary satisfaction with the program has consistently remained over 90 percent.[29] Large health plans and PBMs are able to demand substantial discounts and rebates from manufacturers that offer medicines that compete with other brand drugs or with biosimilars and generics. In some instances, rebates represent a discount of 50 percent or more off products' list price, and six of the ten drugs selected for price setting for 2026 are in therapeutic classes where the average rebate was 40 percent or more in 2021.[30]

The introduction of government price-setting for a subset of competing medicines will inevitably prove highly disruptive to this competitive dynamic and lead to unintended consequences that hinder beneficiary access to MFP-selected medicines and/or competing brand medicines. Health plans' and PBMs' continued reliance on manufacturer rebates as a source of income in Part D amplifies the disruptive effects of government price-setting, which likely will have the effect of reducing manufacturer rebates. This risk was underscored in CMS' most recent national health expenditure projection, in which the Agency estimated that government spending in Part D will *increase* by 12 percent in 2026, largely due to the loss of manufacturer rebates under IRA on MFP medicines.[31]

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[25] For instance, American College of Rheumatology. (2024). American College of Rheumatology Health Policy Statements: Remove Barriers to Patient Access to Treatment, Access to Treatment under Medicare Part D. Available at: https://assets.contentstack.io/v3/assets/bltee37abb6b278ab2c/bltd84782969d741aba/acr-health-policy-statements.pdf

[26] Kent D.M., Nelson J., Dahabreh I.J., et al. (December 1, 2016). Risk and Treatment Effect Heterogeneity: Re-Analysis of Individual Participant Data from 32 Large Clinical Trials. International Journal of Epidemiology. Available at: https://pubmed.ncbi.nlm.nih.gov/27375287/, https://pubmed.ncbi.nlm.nih.gov/15595946/

[27] Hayden CG. (September 4, 2023). IRA: Patient Access to Therapeutic Options. Available at: https://haydencg.com/ira-patient-access-to-therapeutic-options/.

[28] Fraenkel L., Bathon J.M., England B.R., et al. (July 2021). 2021 American College of Rheumatology Guideline for the Treatment of Rheumatoid Arthritis. Available at: https://assets.contentstack.io/v3/assets/bltee37abb6b278ab2c/blt9e44ccb701e1918c/63360f6775c0be225b8d943a/ra-guideline-2021.pdf

[29] Medicare Today. (August 2023). Senior Satisfaction Survey. Available at: https://www.medicaretoday.org/resources/senior-satisfaction-survey

[30] MedPAC. (June 2023). MedPAC Report to Congress, Table 2-1. Available at: https://www.medpac.gov/wp-content/uploads/2023/06/Jun23_Ch2_MedPAC_Report_To_Congress_SEC.pdf

[31] CMS. (June 12, 2024). Office of the Actuary in the Centers for Medicare & Medicaid Services, National Health Expenditures Projections, National Health Expenditure Projections, 2023–32. Available at: https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/projected. See also: Fiore J., Madison A., Poisal J, Cuckler G., Smith S., Sisko A., Keehan S., Rennie K., Gross A. (June 2024). National Health Expenditure Projections, 2023-32: Payer Trends Diverge as Pandemic-Related Trends Fade. Health Affairs. Available at: https://www.healthaffairs.org/doi/10.1377/hlthaff.2024.00469

Despite CMS acknowledging the importance of patient access to a range of medicines, the sharp dislocations that the IRA brings to Part D are likely to create significant pressure on plans to strictly control utilization and maximize rebates and other discounts.[32] This could exacerbate plans' use of UM and coverage exclusions in ways that result in clinically inappropriate barriers to access. As a result of these changing dynamics, access to medicines selected for price setting as well as their non-selected competitors in the same therapeutic class may be threatened, with results varying depending on the dynamics within each therapeutic class. CMS should make use of the full extent of its authority to ensure patient access is not disrupted, including ensuring that patients who are stable on an MFP-selected drug or a treatment alternative in the same class are not inappropriately switched to a different medicine or face other barriers to continued access.

In its Revised Guidance for IPAY 2026 and the Draft Guidance for IPAY 2027, CMS proposes to remedy its concerns about access to selected drugs by requiring plans to provide a "reasonable justification" for disadvantaging selected drugs in coverage. CMS will "evaluate these justifications for compliance with applicable statutory and regulatory requirements" and only approve a plan if it complies with those requirements.[33] Unfortunately, there is no basis for knowing whether this approach will protect patients' access to selected drugs. As a group of academic leaders recently wrote, "CMS plans to assess formulary placement and use of UM tools that may influence access to negotiated drugs, but it has not yet provided guidance on how it will do so, nor on the consequences for plans' undesirable behavior."[34] Moreover, many of the underlying regulatory requirements that CMS will apply are vague, fluid and lack transparency (e.g., "best practices" and "current industry standards"[35]).

While we appreciate CMS' discussion of steps it will take to ensure beneficiary access to MFP selected medicines, we don't believe these steps are sufficient to protect beneficiaries. As CMS has acknowledged, there are circumstances in which plans and PBMs may be incentivized to establish increased access barriers for MFP selected drugs relative to competing medicines.[36] For example, in instances where CMS sets an MFP for a medicine within a competitive drug class that offers significant rebates, plans and PBMs may choose to give preferential status to a competing medicine and establish more significant UM or higher cost sharing for the MFP selected medicine.

At the same time, CMS also must recognize and address the risk of government price-setting disrupting access for Medicare beneficiaries receiving non-selected medicines that compete with the MFP drug. For example, there may be other instances where manufacturers of competing medicines are unable to match the CMS-set price of a MFP selected medicine, leading the plan to prefer the selected drug irrespective of whether it is the most clinically appropriate.

Recent research serves to reinforce concerns that beneficiaries will face increased, potentially inappropriate access barriers to clinically important treatment options as a result of government price setting.[37] For example, in one recent survey of payers, 65 percent said they expect to reduce the number of medicines covered on their formulary

[32] Kelly C. (April 16, 2024). Medicare Negotiated Drugs May Not Get Favorable Coverage in Part D: Will CMS Intervene? Pink Sheet. Available at: https://pink.citeline.com/PS150091/Medicare-Negotiated-Drugs-May-Not-Get-Favorable-Coverage-In-Part-D-Will-CMS-Intervene

[33] IPAY 2027 Initial Guidance at 123.

[34] Arad N., Hoover G., Evans R., McClellan M.B. (April 9, 2024). Medicare Drug Price Negotiations: Policy Implications of the First 10 Drugs' Features. Health Affairs. Available at: https://www.healthaffairs.org/content/forefront/medicare-drug-price-negotiations-policy-implications-first-10-drugs-features.

[35] CMS. Medicare Prescription Drug Benefit Manual Chapter 6 – Part D Drugs and Formulary Requirements. Available at: https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Part-D-Benefits-Manual-Chapter-6.pdf, Section 30.2.2.

[36] IPAY 2027 Initial Guidance at 122.

[37] Fein A. (April 5, 2024). Implications of the IRA: Why the IRA Will Encourage Part D Plans to Prefer High-List, High-Rebate Drugs. Drug Channels. Available at: https://www.youtube.com/watch?v=F5Rjkw7h4gk

for therapeutic classes with selected drugs, and nearly half of payers reported they are likely to exclude most non-selected drugs in the same therapeutic class as a selected drug. [38]

We urge CMS to describe the specific steps it is taking to update and strengthen its formulary standards and oversight and to ensure these safeguards are applied both to MFP-selected medicines and competing medicines in the same class. CMS price-setting under the IRA will inevitably increase the risk of inappropriate UM and formulary restrictions that compromise beneficiary access to medically appropriate care. Thus, CMS must rethink its approach to formulary review for all Part D medicines – including selected drugs, non-selected medicines, and even to ensure adequate access to medicines in the six protected classes – and must engage patients, clinicians, and other stakeholders in a formal process to achieve this.[39]

***The IRA threatens to exacerbate barriers to accessing medicines under Medicare Part D.***

While UM strategies like prior authorization (PA) can play a useful role in ensuring that patients receive clinically-appropriate medicines and at lower costs, research shows that excessive UM restrictions may also harm Medicare beneficiaries by delaying treatment, substituting less effective medicines, and decreasing medication adherence – potentially leading to avoidable progression of diseases and harmful health effects.[40] The potential harms call for effective standards to assure that any UM imposed by PBMs or Part D plans is clinically appropriate, not a barrier to patients receiving the medicine they need.

A study published earlier this year in *Health Affairs* underscores that cause for concern, showing that Part D formularies have become significantly more restrictive over the past decade.[41] In 2011, Part D plans excluded an average of 20.4 percent of compounds from their formularies and placed PA or step therapy restrictions on another 11.5 percent. By 2020, those numbers jumped to 30.4 percent and 14 percent respectively. Part D plans placed the greatest number of access restrictions and exclusions on brand-name-only compounds, with a total of 68.4 percent of brand-name-only compounds facing some sort of UM restriction in 2020. These data underscore the importance of improving CMS' existing formulary and UM standards as IRA threatens to diminish access further.

*Prior Authorization and Step Therapy*

In recent years, multiple stakeholders have conducted analysis that demonstrates the negative effects of inappropriate UM on patients. For example, the National Health Council (NHC) released a report on the burden of PA on patients with chronic diseases, noting that PA processes can result in treatment delays, including delays for necessary drugs, and harm care quality. [42] Step therapy[43] can also be implemented in ways that have a negative impact on patients' adherence to their medicine regimens.[44] Indeed, one study found that low-income Medicare beneficiaries who faced PA restrictions on a drug reduced their use of that drug by 26.8 percent – with

[38] Magnolia Market Access IRA Payer Insights Survey. (2023). Respondents (n=26) represent ~259M covered US lives. See also: Myshko D. (March 19, 2024). Payers Question CMS' Ability to Get Discounts Through Drug Price Negotiation. Formulary Watch. Available at: https://www.formularywatch.com/view/payers-question-cms-ability-to-get-discounts-though-drug-price-negotiation

[39] See Appendix C (Strengthening Access and Formulary Protections in Medicare Part D) for further recommendations.

[40] Joyce G., Blaylock B., Chen J., Van Nuys K. (March 2024). Medicare Part D Plans Greatly Increased Utilization Restrictions on Prescription Drugs, 2011-20. Health Affairs. Available at: https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2023.00999. See also: Weeda E., Nguyen E., et al. (October 29, 2019). The Impact of Non-Medical Switching Among Ambulatory Patients: an Updated System Literature Review. Journal of Market Access & Health Policy. Available at: https://pubmed.ncbi.nlm.nih.gov/31692904/

[41] Joyce G., Blaylock B., Chen J., Van Nuys K. (March 2024). Medicare Part D Plans Greatly Increased Utilization Restrictions on Prescription Drugs, 2011-20. Health Affairs. Available at: https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2023.00999

[42] Pinn A., Witting L.L.Q., Gascho E., Escontrias O,A. (November 2023). NHC Report: Exploring the Burden of Prior Authorization on Patients with Chronic Disease. National Health Council. Available at: https://nationalhealthcouncil.org/wp-content/uploads/2023/11/NHC-Report-Exploring-the-Burden-of-Prior-Authorization-on-Patients-with-Chronic-Disease.pdf

[43] The previously cited Magnolia payer survey cited suggests such programs will become more common as a result of IRA.

[44] Joyce G., Blaylock B., Chen J., Van Nuys K. (March 4, 2024). Medicare Part D Plans Greatly Increased Utilization Restrictions on Prescription Drugs, 2011-20. Health Affairs. Available at: https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2023.00999

approximately half of those beneficiaries receiving no drug at all.[45] This underscores the importance of ensuring that any UM requirements are clinically appropriate. CMS should consider whether, in addition to reviewing a formulary's overall clinical appropriateness for the Medicare population, it should also more closely review the formulary's effects on beneficiary access and adherence to clinically appropriate medicines, particularly in drug classes with one or more drugs subject to CMS price setting.

The increased imposition of UM restrictions by health plans and PBMs in Part D already has taken a toll on Medicare beneficiaries, and these impacts stand to worsen under the IRA. This is because plans likely will have a financial incentive to deter access to certain medicines (depending on the circumstances, either a selected drug or its non-selected competitors), regardless of which medicine is most clinically appropriate for a given patient. Part D plans are not required under the IRA to cover medicines not subject to price setting, and plans retain latitude to apply UM to covered drugs. In the wake of IRA, Part D plans likely will rely on even more UM and other formulary controls, resulting in plans imposing financially motivated access barriers for patients. These dynamics are likely to disproportionately hurt disadvantaged groups, exacerbating health inequities.[46] There is great concern that a patient's access to the best treatment options will be impeded.[47]

*Formulary Exclusions*

In addition to the increases in PA and step therapy, Part D plans have increasingly excluded medicines from plan formularies, depriving patients of critical access to their medicines. While formulary exclusions historically were applied to brand drugs with generic equivalents or drug classes with multiple brands, plans are increasingly imposing exclusions for drugs for complex conditions such as cancers and autoimmune diseases.[48] As discussed, a recent payer survey reports that nearly two-thirds of plans expect to further increase formulary exclusions in classes with drugs selected for IRA price setting, which would inevitably create more barriers between patients and the medicines they need.

Formulary exclusion is a particularly harsh tool to restrict patient access to medicines, as it requires beneficiaries to successfully navigate the complicated and cumbersome process for formulary exceptions or pay out of pocket. And the narrower formularies imposed by Part D plans have negative consequences for patients – decreased choices of medicines and a reduced likelihood of being able to obtain a medicine that's optimal for their medical condition. These consequences are expected to worsen under the IRA and must be addressed by CMS.

***CMS has failed to protect patients from reduced access to medicines resulting from government price-setting.***

Even before the impacts of the IRA are fully realized, CMS' current formulary review standards have not kept pace with the increase in UM restrictions. CMS' current standards are mostly focused on process and are opaque, allowing plans to erect barriers to high value treatment at the expense of patients. For example, CMS' current formulary benefit review includes looking at criteria such as existing "best practices," "industry standards," and "appropriate guidelines," and asking Part D sponsors for a "reasonable justification" for practices falling outside of those practices/standards/guidelines.[49] These terms are not defined and are insufficient to ensure appropriate oversight of UM restrictions.

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[45] Brot-Goldberg, Z.C., Burn S., Layton T., Vabson B. (January 2023). Rationing Medicine Through Bureaucracy: Authorization Restrictions in Medicare. National Bureau of Economic Research. Available at: https://www.nber.org/system/files/working_papers/w30878/w30878.pdf.

[46] Thorpe K.E. (June 27, 2024). Penny Wise And Pound Foolish: IRA Impact On Chronic Disease Costs In Medicare. Health Affairs. Available at: https://www.healthaffairs.org/content/forefront/penny-wise-and-pound-foolish-ira-impact-chronic-disease-costs-medicare.

[47] Hayden Consulting Group. (September 4, 2023). IRA: Patient Access to Therapeutic Options. Available at: https://haydencg.com/ira-patient-access-to-therapeutic-options/.

[48] Joyce G., Blaylock B., Chen J., Van Nuys K. (March 2024). Medicare Part D Plans Greatly Increased Utilization Restrictions on Prescription Drugs, 2011-20. Health Affairs. Available at: https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2023.00999

[49] CMS. (January 15, 2016). Medicare Prescription Drug Benefit Manual Chapter 6 – Part D Drugs and Formulary Requirements. Section 30.2.2. Available at: https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Part-D-Benefits-Manual-Chapter-6.pdf.

Given the changing incentives that IRA establishes, both for selected as well as non-selected medicines, and the growing risks to beneficiary access in Part D, CMS should update and strengthen current Agency oversight and standards for formulary design in Part D.

The Guidance, as well as existing CMS regulations and Part D sub-regulatory guidance, must be revised to fortify protections for patient access to medicines in the wake of the IRA. The current Guidance does little to account for the patient perspective, heterogeneity or clinical nuance and must be strengthened in these areas to better ensure medication access for patients and protect against plan adoption of increased UM. Specifically, we urge CMS to broadly establish stronger standards and oversight for Part D formularies, for all medicines in classes or categories with one or more selected drugs, as well as other therapeutic classes, including the six protected classes. For our detailed recommendations on what CMS can do to strengthen access and formulary protections in Medicare Part D, see Appendix C (Strengthening Access and Formulary Protections in Medicare Part D).

## III. CMS' implementation of the Program undermines competitive marketplace dynamics, which successfully drive patient access to new medicines and cost containment.

Our health care system is designed to promote incentives for continued innovation and patient access while leveraging competition to achieve cost containment. Brand medicines face robust competition from generic drugs, biosimilars, and other brand medicines, which PBMs and insurers have historically leveraged to negotiate rebates and discounts from biopharmaceutical manufacturers. As noted above, this dynamic often occurs with multiple competing brand medicines in the same class. For example, less than a year after market entry of the first highly effective curative treatments for hepatitis C virus, multiple other products entered the market, some offering improved cure rates for patients. The resulting competition was so fierce that the average net daily cost for this class today is nearly 80 percent lower than the first product's launch price.[50] Further illustrating this point, a recent study found that new brand medicines launched between 2013 and 2017 led to an immediate decrease in the average net price of competitors already on the market.[51] As a result of competitive dynamics, medicines continue to represent just 14 percent of overall health care spending.[52]

The marketplace is also uniquely designed to promote innovation and affordability simultaneously through the product lifecycle. Underscoring this point, CBO found that the average net price per prescription in Medicare Part D and Medicaid declined between 2009 and 2018, despite the introduction of many new treatments and cures.[53] This is because over time, new medicines help to improve patient health and reduce overall health care costs while also paving the way for lower-cost generics and biosimilars. Similar cost containment mechanisms do not exist in other parts of our health care system.[54]

Unfortunately, the IRA and CMS' implementation of the Program undermine the success of this system by substituting government price setting for future competition from generics and biosimilars. Specifically, the IRA allows the government to impose such low prices on an innovator product that biosimilar and generic manufacturers may not be able to compete, discouraging them from bringing products to market in the first place. This risk is further heightened by the inability of generic and biosimilar manufacturers to predict with any

[50] Silseth S., Shaw H. (June 11, 2021). Analysis of prescription drugs for the treatment of hepatitis C in the United States. Milliman. Available at: https://www.milliman.com/en/insight/analysis-of-prescription-drugs-for-the-treatment-of-hepatitis-c-in-the-united-states
[51] Dickson S., Gabriel N., Hernandez I. (August 2023). Changes in Net Prices and Spending for Pharmaceuticals After The Introduction Of New Therapeutic Competition, 2011–19. Health Affairs. Available at: https://www.healthaffairs.org/doi/10.1377/hlthaff.2023.00250
[52] Altarum Institute. (July 2022). Projections of the Non-Retail Prescription Drug Share of National Health Expenditures. Available at: https://altarum.org/sites/default/files/uploaded-publication-files/ProjectionsCMS20of%20NonRetail%20Drug%20Share%20of%20NHE%202022.pdf
[53] CBO. (January 19, 2022). Prescription Drugs: Spending, Use, and Prices. Available at: https://www.cbo.gov/publication/57050
[54] For example, the price of a medicine commonly used to prevent cardiovascular disease dropped 95% between 2007 and 2017, while the average charge for a surgical procedure to treat it increased 94% over the same period. PhRMA analysis of Healthcare Cost and Utilization Project (HCUP). National (Nationwide) Inpatient Sample (NIS) database. 2007, 2017. Available at: https://www.ahrq.gov/research/data/hcup/index.html; IQVIA analysis for PhRMA. Invoice price data for atorvastatin 10mg from IQVIA National Sales Perspectives data for 2007 (branded Lipitor) and 2017 (generic). June 2020.

certainty, when they need to make their investment and development decisions, whether or when the branded reference product they are seeking to compete against will be selected for price setting under the Program.

Specifically, regarding small molecule drugs, the IRA undermines existing incentives for generic competition by implementing price setting far earlier than current timelines for generic competition. Currently the average effective patent life for small molecule drugs before generics enter the market is 13 to 14 years.[55] Under the IRA, generics manufacturers must weigh the economic viability of entering the market to compete against a brand product that may already have a low government-set price. But generics rely on the ability to offer sharply lower prices to attract market share from brand competitors. In fact, generics often enter the market immediately upon patent expiration and are often adopted rapidly because of this successful dynamic. Today, 90 percent of prescriptions filled are filled with generic medicines and many capture as much as 90 percent of the market within 3 months of entry.[56] But the IRA's price setting provisions upend incentives that currently drive market entry.

Additionally, the IRA will strongly discourage biosimilar development, as the price-setting timelines imposed under the law are at odds with the framework created under the biosimilar regulatory pathway created under the Biologics Price Competition and Innovation Act (BPCIA). Under the Program, biologics may be eligible for price setting at year 11, with the government-set price going into effect 2 years later, unless there is an approved and marketed biosimilar. However, under the BPCIA, a biosimilar cannot be approved until at least 12 years after the first licensure of the reference biologic. To mitigate against this tension, a special rule was established in the IRA, which allows for potential biosimilar manufacturers to request a "pause" in the price setting process if there's a "high likelihood" for biosimilar marketing within the requisite timeframe. Unfortunately, the biosimilar pause provisions leave too much uncertainty as to whether a drug with a marketed biosimilar can qualify.

To make matters worse, CMS has also imposed an extra-statutory "bona fide marketing" standard, entirely of its own invention, that would leave significant ambiguity as to whether it will be possible to avoid price setting even when there is a marketed biosimilar. These realities make the decision to invest in biosimilar development extremely risky and potentially financially infeasible moving forward. Biosimilar manufacturers face long development timelines and significant costs due to the complexities of biologics manufacturing.[57] As a result of the uncertainty around navigating the pause and the prospect of competing against a government price-set product, the Program – if implemented as CMS has described in Draft Guidance - is likely to serve as a significant disincentive for biosimilar manufacturers in entering the market. For our recommendations on what CMS can do to mitigate against these disincentives and improve the biosimilar pause and its interpretation of "marketed," see Appendix A (Drug Selection) to this letter, which is focused on Drug Selection and related issues.

CMS' list of drugs selected for price setting in 2026 already illustrates the risk that government price setting will undermine market competition.[58] In fact, the majority of medicines on CMS' list of selected drugs for IPAY 2026 already have anticipated generic and biosimilar competition before the IPAY.[59] However, due to the provisions in the IRA and CMS' flawed interpretation, if the pending generic and biosimilar products are unable to reach the market in time for CMS to determine by August 1, 2024 that "bona fide" marketing exists, they will be forced to compete against price-controlled products. This jeopardizes future competition and savings driven by generics and

[55] Grabowski H., Long G., Mortimer R., Bilginsoy M. (January 2021). Continuing trends in U.S. brand-name and generic drug competition. Journal of Medical Economics. Available at: https://pubmed.ncbi.nlm.nih.gov/34253119/
[56] AAM. (September 2023). The U.S. Generic & Biosimilar Medicines Savings Report, September 2023. Available at: https://accessiblemeds.org/sites/default/files/2023-09/AAM-2023-Generic-Biosimilar-Medicines-Savings-Report-web.pdf
[57] Blackstone E.A., Joseph P.F. (September 2013). The Economics of Biosimilars. American Health & Drug Benefits. Available at: https://pubmed.ncbi.nlm.nih.gov/24991376/
[58] HHS. (August 29, 2023). HHS Selects the First Drugs for Medicare Drug Price Negotiation. Available at: https://www.hhs.gov/about/news/2023/08/29/hhs-selects-the-first-drugs-for-medicare-drug-price-negotiation.html
[59] Analysis based on publicly available information at FDA Orange Book and Purple Book and press sources. Additional generic applications may be pending with FDA beyond the 3 noted.

biosimilars in the years ahead. These savings totaled $408 billion last year alone, including $130 billion to Medicare.[60]

## IV. CMS' implementation of the Program will do irreparable harm to innovation to the detriment of patients.

The IRA and CMS' implementation of the Program have also disrupted the incentives which have driven the development of innovative medicines over the years. The price setting framework sets an arbitrary ceiling on prices and allows CMS to set the price at any level below that ceiling for drugs 9 to 13 years after initial FDA approval (and for forms of a selected drug, price setting could occur even earlier due to CMS' approach to defining QSSD). In this section, we detail the mechanisms by which price-setting shifts existing R&D incentives and jeopardizes the future development of medicines in certain therapeutic areas with very real consequences for patients. While each of these disincentives may affect biopharmaceutical companies differently given varying areas of expertise and focus, across the market, the IRA, and CMS' interpretation of the statute, is anticipated to discourage:

- **Post-Approval Innovation.** CMS' broad definition of QSSD, as well as when drugs become eligible for negotiation within their lifecycle, discourage R&D that occurs after a drug or biological is initially FDA approved.
- **Development of Small Molecule Medicines.** By affording small molecule medicines less time on the market after FDA approval prior to entering negotiation, the IRA disincentivizes their development.
- **Development of Orphan Drugs.** Although the IRA exempts certain orphan drugs from negotiation, CMS' overly narrow interpretation of the exemption's eligibility criteria will further harm innovation for these diseases.
- **Development of Treatments for Chronic Diseases.** The list of drugs subject to negotiation is overwhelmingly comprised of medicines to treat common chronic illnesses, signaling that investing in these medicines may impose significant uncertainty and risk.

***CMS' implementation of the Program will create disincentives to post approval R&D and the development of small molecule medicines which are critical for driving treatment advances in certain disease areas.***

Under the framework, selected medicines will face price setting earlier than they may otherwise face generic or biosimilar competition. Shortening the timeframe by which manufacturers can earn revenues on medicines after initial approval and before price setting may occur is expected to upend existing R&D incentives.[61] Specifically, biopharmaceutical companies will now be forced to make difficult decisions about whether it is feasible to invest in R&D occurring after initial FDA approval that could lead to important new uses of already approved medicines. This is particularly true given it can take an additional four years or more to complete costly phase III clinical trials to support a post-approval indication, and companies must consider whether there will be sufficient time on the market to earn revenue before price setting may occur. Unfortunately, any advancements for patients are realized through continued investment in this form of R&D to bring new treatments for different diseases or patient populations.

Additionally, by affording small molecule medicines a shorter timeframe on the market relative to other medicines before price setting may occur, the "pill penalty" especially discourages the development of these critical treatments. Moreover, given the relatively shorter timeframe the pill penalty also particularly jeopardizes the post-approval R&D that is necessary to realize their full therapeutic potential. In fact, research shows more than half of

[60] AAM. (September 2023). The U.S. Generic & Biosimilar Medicines Savings Report, September 2023. Available at: https://accessiblemeds.org/sites/default/files/2023-09/AAM-2023-Generic-Biosimilar-Medicines-Savings-Report-web.pdf

[61] Philipson T.J., Ling Y., Chang R. (October 2023). The Impact of Price Setting at 9 Years on Small Molecule Innovation Under the Inflation Reduction Act. The University of Chicago. Available at: https://ecchc.economics.uchicago.edu/files/2023/10/Small-Molecule-Paper-Final-Oct-5-2023.pdf.

small molecule medicines approved a decade ago received additional indications in later years, and nearly half of those occurred seven or more years after initial approval.[62] One of the reasons small molecule medicines play such a critical role in the treatment of many diseases is their unique ability to reach therapeutic targets inside cells. For example, in diseases such as cancer where the genetic changes that drive cancer cell growth begin inside cancer cells, this feature makes these medicines an important part of the treatment arsenal. Similarly, the ability for these medicines to cross the blood-brain barriers also makes them critical in the treatment of disease with therapeutic targets inside the brain—including illnesses that impact the central nervous system, mental health conditions, neurodegenerative diseases, and many more.[63]

In disease areas where most medicines approved by the FDA are small molecules and post-approval R&D has been indispensable in driving progress for patients, the impact of price setting is expected to be substantial. For example, one study found more than 60 percent of small molecule *cancer* drugs approved between 2006 and 2012 received at least one post-approval indication, and nearly half of those occurred seven or more years after initial approval.[64] Similarly, another analysis examining *cardiovascular* medicines approved between 1995 and 2021 found 92 percent were small molecule medicines and among these, nearly half of approved indications were approved seven or more years after initial approval.[65] Unfortunately, many of these indications may be foregone moving forward. In fact, one analysis by researchers at the University of Chicago found the IRA's price setting provisions would translate to a total of 79 fewer small molecule medicines, and 188 fewer post approval indications over the next 20 years.[66]

Moreover, CMS' approach to setting that price may penalize manufacturers for having "recouped" R&D costs. Not only is this approach flawed but it is based on a fundamental misunderstanding of the biopharmaceutical investment model. As a result, biopharmaceutical companies now must not only consider R&D investment decisions in light of price setting but also how those decisions may affect the government-set price if price setting will apply. In both instances, the Program and CMS' approach to setting a price disrupt existing regulatory and market incentives which have historically aligned the R&D enterprise to drive innovation to meet the unmet needs of patients and instead realigned those incentives towards considering the application of government intervention and its consequences.

***CMS' interpretation of the orphan drug exclusion threatens the development of new medicines to meet unmet needs for patients with rare diseases.***

Unfortunately, CMS' interpretation of the orphan drug exclusion under the Program is overly narrow and undermines existing R&D incentives under the Orphan Drug Act (ODA) for developing new treatments for rare diseases. Congress passed the ODA in 1983 to encourage companies to develop orphan drugs when existing market incentives have historically been insufficient to encourage investments, due to small patient populations, significant R&D challenges, and limited probabilities of success relative to other therapeutic areas. Since enactment, more than 600 orphan drugs and biologics have been approved in the US compared to just 10 in the decade before passage.[67] While the IRA provides a specific exemption from price setting for medicines with a

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[62] Partnership for Health Analytic Research. (June 2023). Implications of the Inflation Reduction Act Price Setting Provisions on Post-approval Indications for Small Molecule Medicines. Available at: https://www.pharllc.com/publication/implications-of-the-ira-price-setting-provisions-on-post-approval-indications-for-small-molecule-medicines/

[63] Ibid.

[64] PhRMA. (July 2023). Emerging Value in Oncology: How Ongoing Research Expands the Benefits of Oncology Medicines. Available at: https://phrma.org/-/media/Project/PhRMA/PhRMA-Org/PhRMA-Org/PDF/PhRMA_Emerging-Value-Report/PhRMA_Emerging-Value-Report_FIN-web_July2023_v2.pdf

[65] Grabowski H., Long G. (March 18, 2024). Post-Approval Indications and Clinical Trials for Cardiovascular Drugs: Some Implications of the US Inflation Reduction Act. Journal of Medical Economics. Available at: https://www.tandfonline.com/doi/full/10.1080/13696998.2024.2323903

[66] Philipson T.J., Ling Y., Chang R. et al. (August 25, 2023). Policy Brief: The Potentially Larger Than Predicted Impact of the IRA on Small Molecule R&D and Patient Health. The University of Chicago. Available at: https://ecchc.economics.uchicago.edu/project/policy-brief-the-potentially-larger-than-predicted-impact-of-the-ira-on-small-molecule-rd-and-patient-health/

[67] FDA. (May 12, 2022). Developing Products for Rare Diseases & Conditions. Available at: http://www.fda.gov/ForIndustry/DevelopingProductsforRareDiseasesConditions/default.htm

single orphan designation (and indications only within that designation), the exemption is far too narrow and is expected to shift R&D incentives and negatively impact orphan drug development. To make matters worse, CMS' careless implementation of the Program and disregard for the critical incentives driving orphan drug development is further evidenced by its explicit removal of a statement in this year's Guidance—noting that CMS would consider additional actions it can take in implementing the "Negotiation Program to best support orphan drug development."

Market incentives prior to the enactment of the IRA incentivized biopharmaceutical companies to choose to launch first in small populations such as rare diseases, because they could earn revenues while conducting R&D on additional patient populations. Now, based on CMS' interpretation of the orphan-drug exclusion, companies across the market must grapple with difficult decisions about whether to choose early indications with the greatest economic value. Specifically, even where a drug's initial approval qualifies for the orphan-drug exclusion, CMS has elected to "use the date of the earliest approval of the drug or licensure of the biological product" to determine whether a drug may be selected for price setting, even if the exclusion is lost years later. As a result, promising drugs may be delayed in getting to market as companies may have an incentive to start the clock first with indications impacting larger population sizes. But importantly, it also means in many cases rare disease patient populations will have to wait for post-approval indications to treat their illness or these indications ultimately may never be realized given shortened timelines to conduct R&D after initial approval. To put a finer point on this disincentive, while the IRA provided a limited exemption for orphan drugs approved to treat a single rare disease, the exemption does not eliminate the disincentives imposed by the IRA and the Program's broader price setting framework which discourages companies from conducting R&D after initial approval, and CMS' Guidance exacerbates this concern.

Historically, post-approval R&D has been critical to advancing treatments for rare diseases. In fact, a total of 35 percent of orphan drugs had multiple indications between 1990 and 2022 (20 percent were approved for rare and common diseases, and 15 percent were approved for just orphan conditions). Half of all subsequent approvals for orphan drugs came five years after initial approval.[68] As noted by a researcher at Columbia University, "The likely result [of the IRA] will be fewer orphan-first launches and, without such launches, riskier trials for broader indications."[69] For our recommendations for improving implementation of the Orphan Drug Exclusion to mitigate against R&D disincentives for patients with rare diseases see Appendix A (Drug Selection).

***CMS' treatment of medicines containing the same active ingredient or moiety as one drug under the Program discourages the post-approval R&D that results in new drugs and biological products.***

CMS' interpretation of QSSD for the purposes of price setting under the IRA is untethered from the statute and will stifle the development of innovative and lifesaving treatments. CMS' overbroad approach treats new dosage forms and formulations containing the same active ingredient or moiety as the same drug, even if the drug was approved under a different marketing application. As a result, biopharmaceutical companies will have to reconsider the economic feasibility of investing in new drug or biological products that could provide meaningful new treatment options for different diseases or patient populations, or provide a new method of administration, jeopardizing the development of these critical treatments moving forward. As noted by a former FDA official, CMS' broad definition of QSSD will undoubtedly discourage post-approval R&D.[70]

Whether improving adherence for vulnerable patient populations or providing new treatment options for an entirely different disease or patient population, post approval R&D that leads to new drugs and biological products provide meaningful treatment advances for patients. For example, long-acting injectable formulations of antipsychotics have significantly improved patient adherence and treatment outcomes. These medications have

[68] Miller, K.L., Lanthier M. (January 2024). Orphan Drug Label Expansions: Analysis Of Subsequent Rare And Common Indication Approvals. Health Affairs. Available at: https://www.healthaffairs.org/doi/epdf/10.1377/hlthaff.2023.00219.
[69] Masia N. (2024). Will Potential IRA Price Limits Delay Drug Launches? Health Capital Group. Available at: https://www.ispor.org/docs/default-source/intl2024/ispor24masiapt4poster138000-pdf.pdf?sfvrsn=2450c107_0
[70] Lumanity. Potential Impact of the IRA on the Generic Drug Market. Available at: https://lumanity.com/perspectives/potential-impact-of-the-ira-on-the-generic-drug-market/

been available for many years and were initially made available in oral dosage forms that patients were required to self-administer daily. Unfortunately, non-adherence rates to antipsychotic medications are relatively high among those with schizophrenia, ranging from 34 percent to 81 percent.[71] [72] [73] Poor adherence is associated with severe consequences, including greater risk of relapse, hospitalization, and suicide.[74] [75] [76] [77] Today, many of these medications are available as long-acting injectables (LAIs) that can be administered every two weeks to as little as every 6 months, depending on the drug. Real world use studies have shown that LAI antipsychotics improve medication adherence and patient outcomes leading to lower odds of hospitalization and fewer emergency room visits. Among Medicaid beneficiaries with schizophrenia, improved adherence due to LAI antipsychotics generated annual net savings of up to $3.3 billion, or $1,580 per patient per year, driven by lower hospitalizations, outpatient care, and criminal justice system involvement.[78] [79]

Unfortunately, the first set of drugs selected for price setting demonstrates CMS' disregard for the value these medicines provide and for the patient populations that rely on these treatment advances. While CMS was permitted to select 10 drugs for price setting, CMS adopted an overly broad interpretation of QSSD to sweep in a broad range of dosage forms and formulations, including those submitted under entirely different marketing applications. The selection of these drugs and biological products, for which the government-set price will go into effect in 2026, sends a clear signal discouraging any future research on improved dosage forms and formulations to meet unmet needs for various patient populations, including patients outside of Medicare. For example, one selected cancer medicine was originally approved for adults with a form of chronic leukemia. Many years later it was approved for use in a new dosage form for an entirely different disease for pediatric patients: graft versus host disease. The new oral suspension form for this patient population provided an important option for those with difficulties swallowing. While this new dosage form was also approved under an entirely different drug application in 2022, for an entirely different disease and patient population, the drug will nonetheless be treated as the same QSSD and subject to price setting just a year after the drug was approved by the FDA.[80]

Given the IRA's price setting framework and CMS' treatment of new dosage forms and formulations under the framework, the economic incentives driving investment in these types of drugs and biological products will be significantly limited moving forward given they may be swept into government price setting shortly after reaching the market. For our recommendations on how to appropriately identify QSSDs in line with the IRA and mitigate

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[71] Lacro J.P., Dunn L.B., Dolder C.R., et al. (October 2022). Prevalence of and Risk Factors for Medication Nonadherence in Patients with Schizophrenia: A Comprehensive Review of Recent Literature. Journal of Clinical Psychiatry. Available at: https://pubmed.ncbi.nlm.nih.gov/12416599/

[72] Lafeuille M.H., Frois C., Cloutier M., et al. (October 2016). Factors Associated with Adherence to the HEDIS Quality Measure in Medicaid Patients with Schizophrenia. American Health & Drug Benefits. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5123648/

[73] Greene M., Yan T., Chang E., et al. (February 2018). Medication Adherence and Discontinuation of Long-Acting Injectable Versus Oral Antipsychotics in Patients with Schizophrenia or Bipolar Disorder. Journal of Medical Economics. Available at: https://pubmed.ncbi.nlm.nih.gov/28895758/

[74] Sher L., Kahn R.S. (July 10, 2019). Suicide in Schizophrenia: An Educational Overview. Medicina (Mex). Available at: https://www.mdpi.com/1648-9144/55/7/361

[75] Ventriglio A., Gentile A., Bonfitto I., et al. (June 27, 2016). Suicide in the Early Stage of Schizophrenia. Front Psychiatry. Available at: https://pubmed.ncbi.nlm.nih.gov/27445872/

[76] Albert M., McCaig L.F. (September 2015). Emergency Department Visits Related to Schizophrenia Among Adults Aged 18-64: United States, 2009-2011. National Center for Health Statistics. Available at: https://www.cdc.gov/nchs/products/databriefs/db215.htm

[77] Higashi K., Medic G., Littlewood K.J., et al. (August 2013). Medication Adherence in Schizophrenia: Factors Influencing Adherence and Consequences of Nonadherence, a Systematic Literature Review. Therapeutic Advances in Psychopharmacology. Available at: https://pubmed.ncbi.nlm.nih.gov/24167693/

[78] Predmore Z.S., Mattke S., Horvitz-Lennon M. (April 1, 2015). Improving Antipsychotic Adherence Among Patients With Schizophrenia: Savings for States. Psychiatric Services. Available at: https://pubmed.ncbi.nlm.nih.gov/25555222/

[79] Bera R., Offord S., Zubek D., et al. (February 2014). Hospitalization Resource Utilization and Costs Among Medicaid Insured Patients With Schizophrenia With Different Treatment Durations of Long-Acting Injectable Antipsychotic Therapy. Journal of Clinical Psychopharmacology. Available at: https://pubmed.ncbi.nlm.nih.gov/24135840/

[80] Analysis of FDA labels of products on selected drug list. Drugs@FDA. Available at: https://www.accessdata.fda.gov/scripts/cder/daf/index.cfm

against the disincentives described here see Appendix A (Drug Selection).

***The IRA and CMS' implementation of the Program will jeopardize our ability to bend the cost curve and reduce health disparities in the years ahead.***

Six in ten Americans have one or more chronic conditions and 42 percent have 2 or more.[81] Chronic conditions, including mental illness, are the largest drivers of healthcare costs accounting for 90 percent of the $4.5 trillion spent on health care each year.[82] In the years ahead, the number of individuals with 3 or more chronic conditions is projected to nearly double by 2030, greatly increasing the burden of these illnesses and pressures on public programs. Much of this impact is expected to disproportionately affect underserved and marginalized populations, leading to widening health disparities.[83,84,85,86,87]

Better disease management achieved through use of medicines has long been credited with avoiding health complications and spending on other costly health care services. These features in turn have been shown to have the effect of curbing overall Medicare spending growth. For example, between 1999 and 2012, there was a significant reduction in Medicare spending growth for cardiovascular disease, one quarter of which was due to greater use of cardiovascular medicines over this period.[88]

Yet, just as chronic illness is expected to impose an increasing burden on our health care system and public programs, CMS' implementation of the Program is moving our healthcare system in the opposite direction by discouraging investment in chronic disease medicines which offer the best opportunity to reduce healthcare spending. CMS' initial list of drugs eligible for price setting illustrates this disincentive in action as the entire list is comprised of medicines to treat common chronic illnesses such as heart disease, diabetes, cancer and autoimmune diseases.[89] Moreover, CMS is expected to continue to select medicines that treat chronic disease for price setting in the years ahead—ironically due in large part to the high burden chronic illness imposes on the Medicare population.

Research shows these types of shortsighted policies can be expected to reduce the number of medicines developed in the future, including those that offer potential to reduce or eliminate spending on other costly medical care. One study from economists at the University of Chicago estimated that IRA price setting policies would increase overall healthcare spending by $50.8 billion over a 20-year period due to the lost opportunity to realize savings in

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[81] Benavidez GA, Zahnd WE, Hung P, Eberth JM. (February 29, 2024). Chronic Disease Prevalence in the US: Sociodemographic and Geographic Variations by Zip Code Tabulation Area. Preventing Chronic Disease. Available at: https://www.cdc.gov/pcd/issues/2024/23_0267.htm

[82] CDC. (May 2023). Fast Facts: Health and Economic Costs of Chronic Conditions. Available at: https://www.cdc.gov/chronic-disease/data-research/facts-stats/index.html#:~:text=The%20impact%20of%20chronic%20diseases,significant%20health%20and%20economic%20benefits.

[83] Partnership to Fight Chronic Disease. What Is the Impact of Chronic Disease on America? Available at: https://www.fightchronicdisease.org/sites/default/files/pfcd_blocks/PFCD_US.FactSheet_FINAL1%20%282%29.pdf

[84] Buttorff C., Ruder T., Bauman M. (May 26, 2017). Multiple Chronic Conditions in the United States. Rand Corporation. Available at: https://www.rand.org/pubs/tools/TL221.html

[85] U.S. Department of Health and Human Services, Office of Minority Health. Heart Disease and African Americans and Hispanic Americans, Diabetes and African Americans and Hispanic Americans, Obesity and African Americans and Hispanic Americans, Asthma and African Americans and Hispanic Americans, Cancer and African Americans and Hispanic Americans.

[86] Ndugga N., Hill L., Artiga S. (June 11, 2024). . KFF. Available at: https://www.kff.org/racial-equity-and-health-policy/report/key-data-on-health-and-health-care-by-race-and-ethnicity/Key Data on Health and Health Care by Race and Ethnicity. KFF. Available at: https://www.kff.org/racial-equity-and-health-policy/report/key-data-on-health-and-health-care-by-race-and-ethnicity/

[87] Partnership to Fight Chronic Disease. (November 2, 2022). Advancing Health Equity, Improving Health Outcomes for All Could Save U.S. $3.8 Trillion. Available at: https://www.fightchronicdisease.org/latest-news/advancing-health-equity-improving-health-outcomes-all-could-save-us-38-trillion

[88] Cutler D.M., Ghosh K., Messer K.L., et al. (February 2019). Explaining the Slowdown in Medical Spending Growth Among the Elderly. Health Affairs. Available at: https://pubmed.ncbi.nlm.nih.gov/30715965/

[89] HHS. (August 29, 2023). HHS Selects the First Drugs for Medicare Drug Price Negotiation. Available at: https://www.hhs.gov/about/news/2023/08/29/hhs-selects-the-first-drugs-for-medicare-drug-price-negotiation.html

medical care that medicines generate.[90] Unfortunately, the IRA undermines the most effective tool we have to bend the cost curve and reduce health disparities in Medicare moving forward.

## V. CMS has failed to implement proper safeguards to protect patients and clinicians in its implementation of the Program.

***CMS has failed to meaningfully include key stakeholders, such as physicians and clinicians, in the price setting process.***

We appreciate CMS' acknowledgement in the Guidance that it must revisit its approach to engaging stakeholders. It is clear to many that CMS' efforts to solicit and incorporate feedback on both the Program itself, as well as on the selected drugs for IPAY 2026 of the Program, have been seriously deficient. CMS offered two primary opportunities for stakeholders to engage and provide input into the price setting process in IPAY 2026: the Negotiation Data Elements Information Collection Request (ICR), and the Stakeholder Listening Sessions. Both were riddled with fundamental substantive, as well as operational, issues. CMS efforts likely led to the opposite effect of what CMS intended – *discouraging* rather than encouraging a diverse group of stakeholders with robust subject matter expertise from engaging in the IPAY 2026 process.

First, the Data Elements ICR was not an appropriate or complete mechanism to solicit input from patients, clinicians, or caregivers on the factors CMS must consider in determining prices for selected drugs. CMS asked for a significant amount of highly complex and technical data that posed a significant burden on patients and other key stakeholders – especially those from underrepresented or disadvantaged communities. To simply submit data to the Agency, these stakeholders needed to learn how to navigate a structurally complex form, decipher and answer highly technical questions in writing, and collect and provide data on the selected drug and potential therapeutic alternatives all within 30 days. Even worse, CMS declined to meaningfully solicit feedback on topics that are important to patients, clinicians, and caregivers – including clearly asking for their experience with a selected drug and the potential therapeutic alternative(s)[91] – while also imposing arduous word limits on the responses CMS did solicit. Together, these factors impeded a patient's, clinician's, or caregiver's ability to relay a complete narrative regarding their experience with a selected drug or therapeutic alternative.

Second, the Stakeholder Listening Sessions hosted by CMS for IPAY 2026 selected drugs, while perhaps well intended, were ill-conceived and poorly executed. This has been noted not only by patients themselves, but by experts in the field of patient engagement.[92] Issues highlighted by PhRMA and other stakeholders (including participants) include:

- **Lack of transparency into participant selection.** For each session, participation was limited to 20 speakers, though it was unclear to participants and the public how the speakers were selected, whether at random or based on certain criteria and each session only featured an average of 11 speakers per drug.[93]

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[90] Philipson T.J., Di Cera G. Issue Brief: The Impact of Biopharmaceutical Innovation on Health Care Spending. The University of Chicago. Available at: https://ecchc.economics.uchicago.edu/2022/08/03/the-impact-of-biopharmaceutical-innovation-on-health-care-spending/

[91] While CMS included new questions on the patient and caregiver experience in the revised ICR, the questions in Section H of the revised ICR were unnecessarily narrow and worded in a way that may have made it difficult for patients to clearly understand what specifically CMS was seeking in each question. For example, when defining "Therapeutic Alternative" in Questions 27 and 28, CMS used terms such as "drug class," "chemical class," and "therapeutic class," without defining these terms.

[92] Vandigo J., Edwards H.A., Flanagan J.H., Mattingly T.J. (June 24, 2024). Three Ways To Improve The Patient-Focused Listening Sessions In The Medicare Drug Price Negotiation Program. Health Affairs. Available at: https://www.healthaffairs.org/content/forefront/three-ways-improve-patient-focused-listening-sessions-medicare-drug-price-negotiation

[93] Patterson J., Wagner T.D., Campbell J. (November 2023). Three Takeaways from CMS's Patient-Focused Listening Sessions: Toward Improved Patient Engagement. National Pharmaceutical Council. Available at: https://www.npcnow.org/resources/three-takeaways-cmss-patient-focused-listening-sessions-toward-improved-patient

This is disappointing as the selected speakers were primarily white (88 percent) and below the age of 65 (63 percent) which may have obscured the views of Medicare patients and those from underserved or traditionally underrepresented communities.[94] CMS has provided no clarity into if these sessions were smaller than expected because of limited response or interest, or resulting from a decision by the Agency.

- **No meaningful dialogue between the Agency and the participants.** Staff remained in listening mode the entire time and did not provide information for participants to respond to or ask questions or provide feedback after participants spoke. CMS even asked at least one speaker to "reconsider" their statements on the IRA's impact to innovation the week of their listening session,[95] signaling that it may have even been trying to prevent any discussion on the flaws of the IRA.

- **Lack of clarity into conflict-of-interest disclosures.** CMS required participants to disclose "conflicts," though the purpose of those disclosures and what should be disclosed was unclear. Although funding from pharmaceutical companies was named as a potential "conflict," funding from other interested or biased parties – including payers, pharmacy benefit managers (PBMs) or other stakeholders with a vested interest in profiting off lowered drug prices – was not. This could have discouraged participation and confused the audience about participants' potential conflicts (or lack thereof).

- **Lack of accommodation of persons with disabilities.** In general, there were few apparent accommodations of persons with disabilities. At one point, CMS staff appeared to cut off a speaker with a speech impediment because the three-minute time limit had been reached.[96]

CMS has also failed to engage (or publicly disclose how they plan to engage) clinicians at critical junctures in the process. As PhRMA discussed at length in our comments on the IPAY 2026 Guidance, clinicians can offer valuable, real-world experience and insight into the selected drugs and key CMS decision points, including but not limited to identification of therapeutic alternatives, whether a selected drug or therapeutic alternative represents a therapeutic advance or meets an unmet need, and key subpopulations for selected drugs. As noted by physicians, CMS' failure in this regard could have very real consequences for patient access to treatment. Physicians are also in the best position to minimize the negative consequences Program implementation might have on formulary access. A structured process for receiving their input can ensure appropriate clinical reviews are considered in both evidence gathering and evaluation as well as monitoring the extent to which selected drugs and their competitors are appropriately covered on formularies.[97] As one physician has stated, "The [A]gency is required to consider a drug's clinical benefit, whether the drug addresses unmet needs, and what alternative treatments exist. But it's hard to make these determinations without a deep dive into the kind of observations and clinical evidence that physicians acquire from extensive, everyday experience."[98]

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[94] Patterson J., Wagner T.D., Salih R., Shabazz G., Campbell J. (June 2024). Breadth of Patient and Stakeholder Input in CMS's Drug Price Negotiation Program: A Content Analysis of the 2023 Patient-Focused Listening Sessions. Value in Health, Volume 27, Issue 6, S1. Available at: https://www.ispor.org/heor-resources/presentations-database/presentation/intl2024-3898/137099

[95] Czwartacki J.(November 30, 2023). After Participating in CMS's IRA Listening Sessions, I Remain Skeptical of IRA Implementation. RealClearHealth. Available at: https://www.realclearhealth.com/blog/2023/11/30/after_participating_in_cmss_ira_listening_sessions_i_remain_skeptical_of_ira_implementation_995832.html

[96] CMS cut off multiple patients throughout the sessions. For an example, please see the redacted transcript for "Speaker 3" during the Eliquis listening session on October 30th. Available at: https://www.cms.gov/files/document/eliquis-transcript-103023.pdf

[97] Fendrick A.M. (December 14, 2023). CMS Must Obtain Clinician Input Today to Prevent Part D Access Barriers Tomorrow. Health Affairs. Available at: https://www.healthaffairs.org/content/forefront/cms-must-obtain-clinician-input-today-prevent-part-d-access-barriers-tomorrow

[98] Fonseca R. (July 2, 2024). Without Doctor Input, the IRA Could Hurt Patients and Cost Them More. RealClearHealth. Available at: https://www.realclearhealth.com/blog/2024/07/02/without_doctor_input_the_ira_could_hurt_patients_and_cost_them_more_1041650.html.

CMS' lack of engagement is certainly not due to lack of feedback or ideas from stakeholders for how best to engage. To the contrary, principles to conduct patient-centered research have existed for years[99] and there is a wide range of academic and thought leader research[100] on methods to better understand and collect patient and caregiver feedback. In response to CMS' implementation of the IRA, experts in patient engagement, including both academics and patients themselves, have been increasingly vocal and concrete regarding how CMS should best receive information from patients, clinicians, and caregivers, and how they should use that information. [101] For example, NHC hosted a roundtable and subsequently released detailed, actionable recommendations to CMS on how to improve engagement with patients; these recommendations were developed in concert with over thirty different stakeholder groups. Because CMS received such thoughtful input, it is even more deeply disappointing that the Agency did not include a detailed engagement roadmap in the Guidance. Instead, it appears CMS will simply finalize a strategy (a strategy which will hopefully be based on feedback received from stakeholders in response to this Guidance) and move forward. Before that happens, PhRMA strongly encourages CMS to speak with stakeholders who should remain at the center of this process – patients, clinicians, and caregivers.

***CMS has failed to articulate a patient-centered approach to setting prices or implement the few patient protections that were included in the IRA.***

As previously noted, PhRMA strongly believes that CMS has an obligation to mitigate the potential harm to patients caused by the IRA. One way CMS can do this is by ensuring that all aspects of its price setting methodology are centered on the needs of patients. This includes adhering to the few explicit patient protections in the IRA. Unfortunately, there is very little evidence in the Guidance that CMS has taken that important step.

As previously mentioned in Section I of this letter, CMS is required by the IRA to develop a consistent methodology for determining prices for selected drugs. It is safe to assume that development of such a methodology would include, at a minimum, public release of certain aspects of the Agency's decision making. However, CMS has failed to disclose to the public (including in the "negotiations" with manufacturers) sufficient detail surrounding many aspects of its methodology.

CMS' apparent failure to adhere to the requirement that it develop a "consistent methodology" is concerning for a number of reasons, but primarily because it is unclear whether the evidence CMS is relying upon or generating, the manner in which CMS is interpreting the factors, or the methodology itself is centered on the perspective of patients, caregivers and society. If CMS is truly committed to a patient-centered approach, at minimum, the Agency needs to transparently articulate how the feedback gathered from the ICR process, the listening-sessions, and any other form of engagement is being used directly and quantitatively in setting the MFP. Without a formalized methodology, any improvements to data collection will fall flat and prices for selected drugs will not reflect the inherent value patients derive from the selected drugs. A failure to emphasize the needs of patients

[99] For examples, please see principles from the National Health Council (available at: https://nationalhealthcouncil.org/blog/the-nhcs-new-value-classroom-tools-to-help-patient-group-staff-engage-on-a-value-assessment/), the National Pharmaceutical Council (available at: https://www.npcnow.org/sites/default/files/2021-04/npc-guiding-practices-for-patient-centered-value-assessment.pdf), the Patient-Centered Outcomes Research Institute (available at: https://www.pcori.org/engagement/engagement-resources), and PhRMA (available at: https://phrma.org/en/resource-center/Topics/Cost-and-Value/Principles-for-Value-Assessment-Frameworks#:~:text=Clearly%20state%20the%20intended%20use,and%20reporting%20costs%20and%20economic)

[100] Examples of patient engagement research CMS should reference include: dosReis S., Butler B., Caicedo J., et al. (October 2020). Stakeholder-Engaged Derivation of Patient-Informed Value Elements. Patient. Available at: https://pubmed.ncbi.nlm.nih.gov/32676998/. See also: Slejko J.F., Hong Y.D., Sullivan J.L., et al. (September 2021). Prioritization and Refinement of Patient-Informed Value Elements as Attributes for Chronic Obstructive Pulmonary Disease Treatment Preferences. Patient. Available at: https://pubmed.ncbi.nlm.nih.gov/33554310/

[101] Vandigo J., Edwards H.A., Flanagan J.H., Mattingly T.J. (Jume 24, 2024). Three Ways To Improve The Patient-Focused Listening Sessions In The Medicare Drug Price Negotiation Program. Health Affairs. Available at: https://www.healthaffairs.org/content/forefront/three-ways-improve-patient-focused-listening-sessions-medicare-drug-price-negotiation

could lead to significant consequences to patient access to drugs in Medicare Part D, or the ongoing development of future treatments, as discussed earlier in this letter.

Another issue on which CMS has remained silent is how it intends to weigh the two sets of factors against each other. Per the IRA, CMS must consider two sets of factors when setting prices for selected drugs. An emphasis on the factors in Section 1192(e)(2) (related more closely to the value a selected medicine brings to patients) may somewhat mitigate inherent disincentives for continued innovation.[102] However, if CMS places too much importance on factors in Section 1194(e)(1) (related to "manufacturer-specific data"), the result could be a price that entirely disregards the value that medicines bring to patients, and have catastrophic consequences for both patient access and innovation. In the Guidance, CMS has declined to discuss the issue entirely, creating considerable uncertainty for manufacturers and jeopardizing patient access to current and future treatments.

One issue CMS does discuss in Guidance, but only superficially, is the use of cost effectiveness analysis (CEA) methodologies to arrive at prices for selected drugs. Given that the protection against use of discriminatory value metrics is one of the few explicit patient safeguards contained in the IRA, CMS' failure to fully explain how it intends to implement the safeguard is disappointing. CMS states that, "CMS will review cost-effectiveness measures used in studies relevant to a selected drug to determine whether the measure used is permitted in accordance with Section 1194(e)(2), as well as with Section 1182(e) of Title XI of the Act. CMS may use content in a study that uses a cost effectiveness-measure if it determines that the cost-effectiveness measure used is permitted in accordance with the law." However, CMS does not elaborate on specifically what specific methodologies it is considering. Transparency regarding specific methodologies is critical – the issue of what qualifies as discriminatory is currently not only a subject of debate among stakeholders, but also the subject of recent rulemaking within HHS' Office of Civil Rights.[103] And as noted in PhRMA's comments on the IPAY 2026 Initial Guidance, regardless of the specific approach taken, reliance on CEA, whether it is rooted in the quality-adjusted life year (QALY) or another similar metric, as the basis for policy decisions risks further discriminating against the elderly, the disabled, and underserved and underrepresented people of color who are already at higher risk of not receiving the care they need.

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PhRMA appreciates your consideration of these comments. Please feel free to contact Elizabeth Carpenter (ecarpenter@phrma.org) and Jim Stansel (jstansel@phrma.org) if there is any further information we can provide or if you have any questions about our comments.


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[102] We note, however, that the mitigation is limited by the fact that the statutory ceiling price applies even when a higher price would be set based on the factors related to the therapeutic benefits medicines offer to patients.

[103] HHS Final Rule, 89 Fed. Reg. 40066 (May 9, 2024) (value assessment prohibition codified at 45 CFR 84.57); HHS Final Rule, 89 Fed. Reg. 37522 (May 6, 2024).